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Directorate of Distance Education

MA [Sociology]

IV - Semester

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MEDICAL SOCIOLOGY

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SYLLABI-BOOK MAPPING TABLE

Medical Sociology

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INTRODUCTION

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By medical sociology, we mean the examination of the effects of social and cultural factors on health and medicine. The field draws on the methodologies and middle range theories of substantive sociological specialities to elucidate vital health, health services organization, and health care utilization issues. One of the biggest issues of medical sociology addresses how social stratification affect patterns of health and illness behaviour, illness risk, disability, and other health care outcomes.

Medical sociologists' help individuals view the healthcare system as a function of the society and serve it by examining and improving all its facets. He or she applies analytical and interpretive skills to help the healthcare facilities improve the conditions of patients and caregivers. This may be through conducting research on the social factors affecting healthcare, providing education to caregivers and working with people to prevent illnesses and speed up the recovery processes. A medical sociologist thus combines both medicinal and sociological aspects to offer effective solutions.

This book, *Medical Sociology*, is divided into fourteen units. It is written with the distance learning student in mind. It is presented in a user-friendly format using a clear, lucid language. Each unit contains an Introduction and a list of Objectives to prepare the student for what to expect in the text. At the end of each unit are a Summary and a list of Key Words, to aid in recollection of concepts learnt. All units contain Self-Assessment Questions and Exercises, and strategically placed Check Your Progress questions so the student can keep track of what has been discussed.

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BLOCK - I
INTRODUCTION TO MEDICAL SOCIOLOGY, DIFFERENCE BETWEEN SOCIOLOGY OF MEDICINE AND SOCIOLOGY IN MEDICINE AND HISTORICAL DEVELOPMENT OF MEDICAL SOCIOLOGY

UNIT 1 INTRODUCTION TO MEDICAL SOCIOLOGY

Structure

1.0 INTRODUCTION

Medical sociology is concerned with the study of the effects of social and cultural factors on health and medicine. It includes an analysis of medical institutions and organizations with the aim of improving medical and health facilities as well as for solving the existing medical problems and issues. Over the years, medical sociology has made several contributions to the field of medicine such as the study of sick role, illness experience, social construction of illness and medical knowledge among many others. In this unit, the scope, objectives and principles of sociology will be discussed.

1.1 OBJECTIVES

After going through this unit, you will be able to:

- Analyze the scope and relevance of medical sociology to patient care
- Discuss the objectives and principles of medical sociology

1.2 MEDICAL SOCIOLOGY: DEFINITION

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As sociologists published increasingly on health and healthcare, some began identifying themselves as 'medical sociologists'. These early medical sociologists faced resistance from within the field of sociology itself. Many of their colleagues viewed the emerging specialization of medical sociology with disdain and suspicion, contending it was solely an applied activity, often sponsored by those being studied, and lacking theoretical substance. Sociology of medicine referred to studies that examined medicine with sociological questions in the forefront, using sociological concepts and theories and intended largely for a sociological audience. Studies of professions, socialization, and organizations typify this orientation. In contrast, sociology in medicine included studies that used sociological perspectives and knowledge to investigate medically oriented questions. The primary goals were to solve medical problems and improve medical care. Such research included studies on doctor-patient interaction, social factors affecting the delivery of services and obtaining medical care, and social epidemiology of disease. For many years, sociology in medicine was viewed by some sociologists to be of lesser value, because it was applied rather than a pure use of sociology. Today, most researchers believe that first-rate sociological research on health contributes to the development of medical sociology and to the improvement of health and healthcare. In fact, in some circles, the specialization is no longer called medical sociology but rather the sociology of health and illness.

1.2.1 Scope and its Relevance to Patient Care

Sociology of health has made several unique contributions. These include: (i) study of medicine as a profession, (ii) study of the **sick role** (term used in medical sociology regarding sickness and the rights and obligations of those affected) and illness experience, (iii) social construction of illness and medical knowledge, including medicalization, (iv) sociological epidemiology, and (v) sociological study of healthcare services as organizations. In each instance, sociologists have offered a fresh perspective on understanding the issues by examining the impact of power, authority, norms, social inequality, and the distribution of resources. In the following pages, we briefly describe the distinctive sociological stance on each of the aforementioned areas.

In the 1950s and 1960s, the main task of sociologists of health was to involve themselves in the research and draft recommendations for health professionals so that they could treat patients effectively and establish a communication between health providers and patients. This was needed because many times the community was not able to take advantage of medical inventions, technological developments, diagnostic and therapeutic knowledge gained from specialized education in the health field. The study of medical profession is a central area of sociology of health and forms the basis for the sociological study of the professions. Sociological concepts of the profession of medicine have provided

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definitions of professional work and the ways in which a profession obtains and maintains control of expertise. Interest in professional authority in general and medicine in particular led to extensive sociological work on medical education and socialization.

Early works on the profession included Talcott Parsons's (1951) *Explanations of Professional Authority*, Renee Fox's (1957) *Training for Uncertainty*, Howard Becker and colleagues' (1961) *Study of Medical Education and Socialization*, and Eliot Freidson's (1970) *Profession of Medicine*. These studies examined the power and authority physicians hold as a group, the social and economic privileges associated with the status of medicine, and the ways in which the profession has protected these privileges both from competing occupations and from women and minorities who had faced restricted access to the profession. In addition, sociologists have examined inter-professional relations between doctors, nurses and other health professionals (including chiropractors, dentists, and psychologists). They also focused on the roles of professionals in organizations and competition between professionals for authority and autonomy. Furthermore, sociological work has contributed to the understanding of the history of medicine as a 'contested' terrain in which physicians first established and then fought to maintain their professional dominance. Physicians' success in these struggles has shaped healthcare in many years, from doctor-patient interactions to the organization and delivery of care (Starr, 1982; Abbott,1988).

The women's health movement has encouraged sociological research on illness experience through the movement's criticism of medicine for devaluing women's reports of their own health and well-being and their experiences of illness and medical treatment. As a result, sociological studies of illness experience have evolved into a wide range of quantitative and qualitative work. For example, sociologists' focus on the patient's view fostered the development of what is now known as patient-centred outcomes in health services research. Moreover, medical sociologists have contributed to a rapidly growing body of work on women's experiences with reproductive technologies (e.g., Bell, 1988; Reissman and Nathanson, 1986). These two examples represent areas that have become truly interdisciplinary.

A third unique contribution of medical sociology has been the examination of the social construction of illness and medical knowledge. This area includes a range of studies from a social constructionist perspective, including those of the sociological history of diseases, medicalization, and the social meaning of illness (e.g., whether particular illnesses are stigmatized). As Judith Lorber (1977) and others have noted, "what is normal depends on who is being compared to whom". In this body of work, sociologists have examined the ways in which new illnesses have been discovered and characterized, the attribution of new medical knowledge, and the myriad ways in which non-medical events and experiences have entered the purview of medicine.

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Sociologists have also used the constructionist perspective to examine the social processes by which certain constellations of troubles become diseases, such as hypertension. Medicalization and intrusion of medical concerns into everyday life encompass an ever expanding list of health behaviours (diet-exercise, risk prevention, and preventive care compliance). Sociologists bring a different theoretical perspective to the healthcare research by focusing on the multiple ways in which social inequalities contribute to differences in health and by recognizing the persistence of these relationships over time despite ever changing mechanisms that lead to poor health among the disadvantaged.

Finally, sociologists have made a unique contribution to the understanding of healthcare through research on medical care organization. Just as medicine became the prototype for occupational research on the profession, research on hospitals, medical practices, nursing homes, and other healthcare organizations has shaped both our understanding of how care is provided and the power and interests that have shaped the provision of healthcare. Medical sociologists have studied hospitals and mental health institutions as complex organizations designed to meet multiple needs in society, which often involve competing agendas. These organizations are also total institutions with their own norms, roles, actors, and status hierarchies. Failure of patients to seek out appropriate healthcare, communicate fully and reliably symptoms and problems to their providers, follow through on referrals, comply with medical regiments, and engage in appropriate preventive practices bewildered many practitioners and concerned those responsible for medical education and postgraduate training of health providers. The concern for the above issues among healthcare providers lead to a wide range of studies by medical sociologists.

Their findings often questioned assumptions made by physicians and other health providers about patient motivation, barriers in culture and within social structure which hindered effective use of the technology available in medicine and clinical discernment of physicians, and brought into focus the inconsistencies between the interests of healthcare providers and the organizations with which they are associated and those of the patients they treat (Levine, Scotch, and Vlasak, 1969).

During this period, an important teaching function of health sociologists in health science schools was to sensitize physicians and other health professionals to features of their social and cultural backgrounds, personal socialization experiences, and educational careers, as well as to social structural characteristics of their provider organizations, that could impede the successful transmission of their technologies (Zola, 1983). Over time, healthcare sociologists subjected medicine and different aspects of the health system to increasingly critical scrutiny. They challenged the assumptions of biomedical model, questioned the overuse of complex and expensive technology, criticized the asymmetrical features of the doctor-patient relationship, and emphasized the importance of interpersonal, social,

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and economic considerations in efforts at health promotion and the healing of the sick (Mishler et al., 1981). Even more, sociologists were at the forefront in documenting that medical decisions " do not emanate from a routine, scientific calculus but are made by people playing social roles, guided by social values, and located in particular social settings or contexts" (Levine, 1987).

The distance medicine and medical sociology have travelled is evident now in the emergence of quality of life as an overriding social dimension of judging health and illness, and a major criterion to evaluate healthcare in general and technological interventions in particular. The 1950s also saw a revolution of sorts in the care of the mentally ill. This was a response to the inhuman physical and interpersonal environments of mental hospitals, the widespread adoption of drug therapies, the influence of psychodynamics thinking, and the beginning of the social and community psychiatry movements. Sociologists were key players in the spate of activities that occurred in the decade or so that followed. Field studies of mental hospitals (e.g. Stanton and Schwarts, 1954), studies of role behaviour and perspectives of patients and hospital staffs (e.g., Goffman, 1961), social epidemiological studies (e.g., Hollingshead and Redlich, 1958) and follow-up surveys of discharged patients (e.g. Freeman and Simmons, 1977) represented an important fund of information that contributed to a growing body of knowledge about deviant behaviour and organizational relations.

Today, interest in the consequences of mental illness treatment persists. The aftermath of social psychiatric research and social action efforts during the late 1950s and 1960s was a movement to deinstitutionalize just about everyone. The populations of mental hospitals and facilities for persons with retardation and developmental disabilities were sharply reduced. At the same time, community treatment became the vogue. Sociologists turned their attention to the study of programmes, organization, politics, and efficacy of community mental health centres, as well as to the actions of their advocates and opponents. Such work, commonplace in the 1970s, is still popular.

The 1960s and 1970s marked a period that emphasized government programmes to improve the condition of the poor. The Great Society programmes, and those that followed and preceded them included health components even though healthcare was low priority (Freeman, Kiecolt, and Allen, 1982).This resulted in major efforts being undertaken to improve access to care, including the establishment of neighbourhood (later called community health centres), and of reorganized delivery systems in hospitals. Programmes were also implemented to modify the interpersonal relations of professionals and patients in order to increase utilization and compliance. Efforts were also made to increase the number and to re-distribute physicians and other health providers in a manner as to relieve the dearth in rural areas and inner cities. The concern with the poor also entailed a concern with ethnic and racial equality. Thus, attempts to increase the number of minority health science students and providers were also made. The rationale for

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this was based on concerns for equality and on the belief that persons of minority background would be more effective in dealing with patients of their own ethnic background.

Interest in providing access to care, in creating new types of healthcare organizational arrangements, and in expanding minority medical education flourished in the 1970s and continued in the 1980s, in part spurred on by the activities of the Robert Wood Johnson Foundation (Aiken, Blendon, Rogers, and Freeman, 1980). The movement toward Health Maintenance Organizations (HMOs) bloomed, and as a result of their expanded role, increased access to health services and patient care became a major research concern. The concern with the poor, the implementation of government and foundation supported social programmes in general, and health initiatives in particular, were accompanied by a need for hard information on the extent to which the efforts were successfully implemented, effective in their outcomes, and efficient from a cost-benefit standpoint.

Although the assessment of social change efforts and social experiments have a long history, it was the spate of activities in connection with the programmes to reduce poverty and discrimination and to promote more equal access to and use of health and social services that led to the emergence of a new methodological field, generally referred to as 'social programme evaluation' or 'evaluation research' (Rossi and Freeman, 1985). Sociologists in the health arena and in other social programme areas have been key players in the programmes evaluation area. Many of the major health care initiatives have been evaluated by teams led or assisted by sociologists. Moreover, the impetus to improve access to and increase use of health services by the underprivileged to a large extent, required modification of organizational, political, and geographical arrangements for the delivery of health services.

The effort to improve healthcare for the underprivileged is one of the main driving forces for medical sociologists to move into policy research, policy development, macro-planning, and managerial activities. At the same time, it has encouraged health professional schools to integrate the concepts of frames and applied research approaches of sociology into their educational programmes. The 1980s have witnessed a shift in interest, further testifying to the validity of the linkage between the social contexts and the content of scientific and intellectual work. There has been a change in the approach towards conservative ideological thought, with the result that more emphasis is given to accessibility to health services. Further, interventions are also initiated towards minimizing the cost of medical care. However, the cost-containment contains the sociological dimensions as well because it requires important initiative at the level of policy formulation, professional educational effort, organizational modification, recruitment of healthcare providers, and new ways of dealing with political consequences of economic containment decisions. Although the policies have changed and the research questions are different, there is no diminution in opportunities for medical sociologists to contribute

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to work in the health arena and to accrue knowledge of general sociological interest. Emphasis on the cost of care has brought with it increased interest in the quality of medical care.

Any cost containment that limits in some way medical services provided, almost automatically provokes a reaction with regards to impact on patient outcomes and their future well-being. Present topics of sociological interest include studies of the health consequences of patients' membership in different forms of medical care arrangements from solo practice to health insurance schemes. The demographic dynamics, the economic considerations, and the continual technical advancements in medicine compel sociological attention to the issue of quality of life. Simply prolonging life in a biological sense may in many cases have little consequence. The key issue, which is a sociological matter, is how decisions on the use of technology, allocation of economic resources for healthcare, and ways of service delivery affect the quality of life.

The broad-brush examination of the past, present, and future of research opportunities, germane to the interests of medical sociologists, would be incomplete without at least a mention of the sociological ramifications of the Acquired Immune Deficiency Syndrome (AIDS) epidemic. No other single health problem in this century is likely to have comparable consequences for our social structure, for interpersonal relations, and for health resource allocation. Every aspect of the AIDS phenomenon has sociological import, from its etiology (Kaplan et al., 1987) to provider behaviour and patient care (Lewis and Freeman, 1987) to the possible resort to authoritarian means to identify and contain AIDS cases, the advent of massive discrimination against homosexuals and persons with 'pre-AIDS' symptoms and tests results, and restricted access to care and third-party insurance of high risk groups.

1.2.2 Objectives of Medical Sociology

In simple terms, based on the earlier discussion, medical sociology can be defined as a bridge between social factors and health. It also, with the help of sociological theory and research, questions matters related to health and the health care system.

Medical Sociology per se is a sub-discipline that draws from the theories of sociology for emphasizing the importance of health, health services organization, and health care utilization issues. Typical areas of research involve the analysis of the influence of ethnicity, gender, age, or socioeconomic status on a variety of issues related to the quality of health care- health and risk-taking behaviours, health beliefs and perceptions, the role of health institutions and health professionals in society, social constructs of illness, education, and communication, health effects of socio-cultural changes, and other sociological aspects of medical organization and practice.

The objective of this subject is to study health care organizations and their provisions, to an extent that encompasses the changing structures of healthcare

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organizations. It also covers issues such as the social psychology of health and health care.

The endeavour of Medical sociology is to follow two streams viz, sociology in medicine and sociology of medicine. In the first case, sociologists play the role of applied investigators or technicians, seeking to provide answers to different agencies like hospitals, government agencies, medical schools. This role involves interactions with those who design and execute health surveys and who study such topics as the use of services, satisfaction, health status determinants, etc.

Sociology of medicine focuses on the testing of the sociological hypothesis using medicine as an area. The core of the study revolves around analyzing basic issues in social stratification, socialization, social organization, power, and influence, and broadly about the social values. Basically, this explores how physicians control the work of other health operatives; how lower social status and gender affect health interactions. It also delves into the evaluation of how political and economic interests influence the structure of care.

The major areas which are the core concern areas for medical sociology include social determinants of health and disease, the behaviour of patients and health care providers, the social pattern of utilization of health services, and social policies towards health to list a few. The importance of medical sociology lies in the critical role that it performs in determining and influencing the health of individuals, groups, and the larger society. Social conditions and situations can often trigger illness and disability, however, they are equally capable of enhancing the prospect of disease prevention and health maintenance. Today the ambit of medical sociology has evolved to a large extent and it is now a potent tool for investigating health and medical problems from an independent sociological perspective.

1.2.3 Principles of Medical Sociology

Medical sociology or "health sociology", as it is now referred, adopts the basic ideas from general sociology and applies their theories and methods to analyze two major areas of inquiry:

- the social determinants of human health and health-related behaviour
- the social organization of health care, health professions, and their interaction with patients.

The first area is referred to as "sociology in medicine," this is due to its problem-oriented approach that marries sociology with biomedical knowledge. The second area is termed as "sociology of medicine" since it analyzes the health care system from the perspective of a broader social system.

Medical sociology works on the principle and the premise that health and illness cannot be simply regarded as a biological or medical phenomenon only.

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The sociology of health includes disease, social epidemiology, disability, mental health, and medicalization. Medical sociology is perceived, organized, and executed on the lines of cultural, economic, political, and institutional context.

While sociology is about the systematic study of human behaviour in the social domain, medical sociology is about the systematic study of how humans learn to tackle issues of illness, health, disorder, and disease, and general health-related care both for the healthy and the sick. Medical sociologists concern themselves with doctor-patient relationships, explore the cultural impacts and attitudes towards disease and wellness, and study the structure and socioeconomics of health care. Within the domain of medical sociology, the social construction of health occupies a major area as a research topic.

The idea of the social construction of health emphasizes the socio-cultural aspects of the physical definable phenomena. Sociologists, Conrad, and Barker (2010) have comprehensively presented the major findings of the last 50 years with respect to the development of the concept.

The summary presents the findings in the field in broadly three categories- the cultural meaning of illness, the social construction of illness experience, and the social construction of medical knowledge.

As has been mentioned above, there have been dramatic changes in the health status and health care systems over the past 50 years. Medical sociology has also evolved side by side and it has contributed immensely in understanding illness, disease prevention, and the treatment process. These contributions have been studied by Janet R Hankin and Eric R.Writh and presented in their article “Reflections on Fifty Years of Medical Sociology”. Per se the contributions have been distributed into eleven broad areas within medical sociology:

1. Racial-ethnic disparities in health care
2. Fundamental causes of health inequalities
3. Stress and health
4. Social relationships and health
5. The social construction of illness
6. Patient-provider relationships and help-seeking behaviour
7. The social transformation of the medical profession
8. Health service research
9. Technology
10. Bioethics
11. Health reform

The principles of medical sociology have therefore undergone a metamorphosis. The different theories have been tested; some have stood the test of time while the others have either been rejected altogether or have morphed.

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Check Your Progress

1. What did sociology of medicine refer to?
2. List some early works on the profession of sociology of medicine.
3. What is the main driving force for medical sociologists to move into policy research?
4. Which factors compel sociological attention to the issue of quality of life?
5. What is the endeavour of medical sociology?
6. What does sociology of health include?

1.3 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. Sociology of medicine referred to studies that examined medicine with sociological questions in the forefront, using sociological concepts and theories and intended largely for a sociological audience.
2. Early works on the profession included Talcott Parsons's (1951) *Explanations of Professional Authority*, Renee Fox's (1957) *Training for Uncertainty*, Howard Becker and colleagues' (1961) *Study of Medical Education and Socialization*, and Eliot Freidson's (1970) *Profession of Medicine*.
3. The effort to improve healthcare for the underprivileged is one of the main driving forces for medical sociologists to move into policy research, policy development, macro-planning, and managerial activities.
4. The demographic dynamics, the economic considerations, and the continual technical advancements in medicine compel sociological attention to the issue of quality of life.
5. The endeavour of medical sociology is to follow two streams viz, sociology in medicine and sociology of medicine.
6. The sociology of health includes disease, social epidemiology, disability, mental health, and medicalization.

1.4 SUMMARY

- Sociology of medicine referred to studies that examined medicine with sociological questions in the forefront, using sociological concepts and theories and intended largely for a sociological audience. Studies of professions, socialization, and organizations typify this orientation.

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- Today, most researchers believe that first-rate sociological research on health contributes to the development of medical sociology and to the improvement of health and healthcare.
- In the 1950s and 1960s, the main task of sociologists of health was to involve themselves in the research and draft recommendations for health professionals so that they could treat patients effectively and establish a communication between health providers and patients.
- The women's health movement has encouraged sociological research on illness experience through the movement's criticism of medicine for devaluing women's reports of their own health and well-being and their experiences of illness and medical treatment.
- Sociologists have also used the constructionist perspective to examine the social processes by which certain constellations of troubles become diseases, such as hypertension. Medicalization and intrusion of medical concerns into everyday life encompass an ever expanding list of health behaviours (diet-exercise, risk prevention, and preventive care compliance).
- Medical sociologists have studied hospitals and mental health institutions as complex organizations designed to meet multiple needs in society, which often involve competing agendas. These organizations are also total institutions with their own norms, roles, actors, and status hierarchies.
- Any cost containment that limits in some way medical services provided, almost automatically provokes a reaction with regards to impact on patient outcomes and their future well-being. Present topics of sociological interest include studies of the health consequences of patients' membership in different forms of medical care arrangements from solo practice to health insurance schemes.
- In simple terms, medical sociology can be defined as a bridge between social factors and health. It also, with the help of sociological theory and research, questions matters related to health and the health care system.
- Sociology of medicine focuses on the testing of the sociological hypothesis using medicine as an area. The core of the study revolves around analyzing basic issues in social stratification, socialization, social organization, power, and influence, and broadly about the social values.
- While sociology is about the systematic study of human behaviour in the social domain, medical sociology is about the systematic study of how humans learn to tackle issues of illness, health, disorder, and disease, and general health-related care both for the healthy and the sick.

1.5 KEY WORDS

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- **Chiropractor:** It refers to a health care professional focused on the diagnosis and treatment of neuromuscular disorders, with an emphasis on treatment through manual adjustment and/or manipulation of the spine.
- **Health Maintenance Organization (HMO):** It is a network or organization that provides health insurance coverage for a monthly or annual fee. An HMO is made up of a group of medical insurance providers that limit coverage to medical care provided through doctors and other providers who are under contract to the HMO.

1.6 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. What did research in 'sociology of medicine' include?
2. What unique contributions has sociology of health made?
3. How do sociologists bring a different theoretical perspective to healthcare research?
4. What was the aftermath of social psychiatric research and social action efforts during the late 1950s and 1960s?
5. List the two areas of inquiry that medical sociology analyzes.
6. What principle does medical sociology work on?

Long-Answer Questions

1. Discuss the contributions made by sociological work in the field of medicine.
2. Analyze the developments that took place in the 1960s and 1970s with regard to medical sociology.
3. Elaborate upon the objectives of medical sociology.

1.7 FURTHER READINGS

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UNIT 2 DIFFERENCE BETWEEN SOCIOLOGY OF MEDICINE AND SOCIOLOGY IN MEDICINE

Structure

2.0 INTRODUCTION

The history of medical sociology dates back to earlier times. The discipline of medical sociology is seen to be quite rich and varied which goes back to as long as fifty years and more. It explores a lot of healthcare issues which include physician-patient relationship, illness behaviour, stress and coping, the social distribution of health, medical professionalism, health care policy and public health. It is also composed of various sociological theories such as functionalist approach, labeling approach, conflict approach, integrationist approach and so on. Furthermore, it is found to intersect with a wide variety and range of various other types of social sciences, for instance, medical anthropology and health psychology among others. All these together lead to an improvement of medicine and medical sociology and make the living conditions of people better by making them more stable and healthier.

2.1 OBJECTIVES

After going through this unit, you will be able to:

- Discus the historical roots of medical sociology
- Analyze the systems of medicine in India
- Difference between sociology of medicine and sociology in medicine

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2.2 MEDICAL SOCIOLOGY AND MEDICAL EDUCATION

The move to introduce medical sociology played an important role in the discipline's evolution. The first department of Behavioural Science at the University of Kentucky was established in the year 1959 by Robert Strauss. For Strauss, "behavioural science" (note the sin-gular form) reflected the intersection of medical. Further, one finds that there was an increase in the number and size of departments of behavioural science. Strauss's sociology of and in medicine also raises the question of whether there are two (or more) medical sociologies. As such, Talcott Parsons' famous work on the social systems focused on the core aspect of the sociological theory. He has highlighted and discussed in detail about the issues of health and sickness from a functional sociological perspective. On a same line, we find Eliot Friedson who has highlighted in the sociology of knowledge and the framing up of social order which is seen as the product of ongoing human production.

Robert Merton, Leo Reeder, and Patricia Kendall's (1957) *The Student Physician* and Howard Becker et al.'s (1961) *Boys in White* were less studies of medical education per se than they were efforts to test competing theories of social action, including adult socialization.

Medical sociology must include the application of sociological knowledge and concepts to issues of health and illness. There exist structural factors that have an effect on the disease and illness process. These include a lot of things such as culture, values, beliefs, politics, health care, policy, political ideology, and so on.

Historical Roots

Medical sociology can be traced back to earlier decade's as long back as in the 1800s. The term sociology was coined by Auguste Comte in 1839. Sociology as a discipline was found to gain wider popularity and emerging as a distinct discipline. There happens to exist many link between the term sociology and medical. As such one finds that various articles and books were published which described this in detail. For instance there was two articles by Charles McIntire named as "the importance of the study of medical sociology" published in the year 1894 and the other name which was known as the "the expanse of sociologic medicine". Along with these books were also published which became widely popular in due course of time. The first by Elizabeth Blackwell "Essays in medical sociology" and the other one which is James P. Warbasse " (1909) (Medical Sociology: A Series of Observations Touching upon the Sociology of Health and the Relations of Medicine)."During the early 1950s and 1960s the field and discipline of medical sociology underwent significant growth. It was widely supported by various organizations and by private foundations.

Sociology of Medicine and Sociology in Medicine

The field of medicine is found to be divided into three main parts: the former two are about the medicine which is seen as a profession and the doctors are seen as professional workers whereas the third part is about the social construction of illness. The work of Eliot Freidson is seen as the most influential works which gained a large popularity and is still relevant in contemporary times.

The field of sociology of medicine is quite a contemporary discipline which has emerged in the current times and gained popularity in short due course of time. Sociologists are found to be struck to a new social phenomenon in this field which is closely connected with health and illness. For instance, one of the well-known sociologists named Rivers has discussed about the relationship which exists between magic, religion and medicine in his book "Medicine, Magic and Religion" which was published in the year 1924.

Furthermore, earlier times didn't consider much on the fact that the medicinal field happen to consist of number of individuals that interacted with one another and further this interaction between individuals followed a certain type of pattern. Every individual very well knows how that person has to interact with each other. In this way, the interaction of individuals in the field of medicine is found to have been affected by culture of the society. Paul (1955:477) writes: "The threads of health and illness are woven into the socio-cultural fabric and assume full significance only when perceived as part of the total design." When a sociologist happens to study, he looks at health and sickness to be inter related closely. They are even related to various other spheres of life such as that of economy, religion law, politics, and so on.

In India, we find that there exist a variety of ways in which the concept of disease took place and its responses. For instance, disease might be seen in the attribute to man's disobedience of natural and religious laws. It might even be closely related to the sins which an individual has done either in the present life or committed in the previous life. For example, it is widely accepted notion that the individual who happens to kill a Brahmin and becomes a blind person if ne happens to kill a cow. Further, a person might even happen to visit a guru or saint and find on as to how best he could do in order to wash away all of his sins which has led to the disease or any sort if illness in the individual concerned. The service provided by any kind of healer is also taken into consideration. Performing various sorts of prayers, offering milk, flowers, sacrifices are done in order to solicit the deity's blessings. Practicing any kind of treatment at home is also done at a large scale. As such visit any sacred places, taking vows are incorporated into the daily lives of the people. There are also many charismatic leaders present who happen to gives various mantras and charms to the individual so that the individual concerned gets rid from any sort of illness and becomes a healthy individual again. Furthermore,

certain medical skills are seen to be monopolized by particular families which are passed from one generation to next and the knowledge is secretly kept. All of this makes it quite clear that there exists cures for all of these practices.

Systems of Medicine in India

Sociologically, we find that there lies interest in the influence of social status and culture on the individual's health. Durkheim had famous work on suicide. One finds that mainstream classical sociology within the Marxist, Weberian and Durkheimian traditions had paid little attention to health.

There are many systems of medicine in India which exists today. The most famous these are Ayurveda, Unani, Homoeopathy and Allopathy. Apart from all of these, there is presence of many kinds of tribal medicines as well that are many a times based on magic. The Ayurveda system is found to exist and goes back long to the Vedas. According to Filliozat (1964:1), Ayurveda is "... sometimes considered as a secondary part (upanga) of the Atharvaveda and sometimes as a secondary Veda (upa-veda) of the Rig-Veda".

The development of Indian medicine is found in three different ways and three different periods. The first period is that of the Vedas. The second is the Buddhist period. The third period produced the Sanskrit treatises of Charka, Sushruta, Vagbhata and other. The Unani or the Islamic system of medicine came to India with the Muslims and has stayed ever since, drawing an increasing number of students. Furthermore, one finds that people do not tend to differentiate between Ayurveda and Unani medical beliefs and practices.

Check Your Progress

1. When was the first department of behavioural science established?
2. What should medical sociology include?
3. What are the most famous systems of medicine in India?

2.3 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The first department of Behavioural Science at the University of Kentucky was established in the year 1959 by Robert Strauss.
2. Medical sociology must include the application of sociological knowledge and concepts to issues of health and illness.
3. There are many systems of medicine in India which exist today. The most famous of these are Ayurveda, Unani, Homoeopathy and Allopathy.

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2.4 SUMMARY

- For Straus, "behavioural science" (note the sin-gular form) reflected the intersection of medical. Further, one finds that there was growing in number and size of departments of behavioural science.
- Robert Merton, Leo Reeder, and Patricia Kendall's (1957) *The Student Physician* and Howard Becker et al.'s (1961) *Boys in White* were less studies of medical education per se than they were efforts to test competing theories of social action, including adult socialization.
- Medical sociology can be traced back to earlier decade's as long back as in the 1800s. The term sociology was coined by Auguste Comte in 1839. Sociology as a discipline was found to gain wider popularity and emerging as a distinct discipline.
- The field of medicine is found to be divided into three main parts: the former two are about the medicine which is seen as a profession and the doctors are seen as professional workers whereas the third part is about the social construction of illness.
- Paul (1955:477) writes: "The threads of health and illness are woven into the socio-cultural fabric and assume full significance only when perceived as part of the total design."
- The Ayurveda system is found to exist and goes back long to the Vedas. According to Filliozat (1964:1), Ayurveda is ". . . sometimes considered as a secondary part (upanga) of the Atharvaveda and sometimes as a secondary Veda (upa-veda) of the Rig-Veda".

2.5 KEY WORDS

- **Socialization:** It is the process of internalizing the norms and ideologies of society. Socialization encompasses both learning and teaching and is thus "the means by which social and cultural continuity are attained".
- **Classical Sociology:** It is the systematic study of human society and social life in its earliest period that led to its establishment as a scientific discipline.
- **Ayurveda:** It is the traditional Hindu system of medicine (incorporated in Atharva Veda, the last of the four Vedas), which is based on the idea of balance in bodily systems and uses diet, herbal treatment, and yogic breathing.

2.6 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. What did Talcott Parsons' famous work on the social systems focus on?
2. What are the structural factors that have an effect on disease and illness process?

Long-Answer Questions

1. Elaborate upon the historical roots of medical sociology.
2. Discuss the systems of medicine in India.

2.7 FURTHER READINGS

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UNIT 3 DEVELOPMENT OF MEDICAL SOCIOLOGY

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Structure

3.0 INTRODUCTION

Medical sociology began to develop in the 1940s when funding for joint research by medical sociologists and doctors became available in large amounts. It primarily became a serious discipline with Talcott Parsons' theory of the 'Sick Role'. It was after this development that sociologists began researching independently in the field of medicine from a purely sociological perspective. Over time other concepts of medical sociology were developed that include the ecological, biomedical, holistic and psychosocial concepts.

3.1 OBJECTIVES

After going through this unit, you will be able to:

- Analyze the historical development of medical sociology
- Discuss sociological perspectives on health and illness
- Examine the biomedical, ecological, psychosocial and holistic concepts of medical sociology
- Understand the relationship of health and illness and the concept of sick role

3.2 HISTORICAL DEVELOPMENT OF MEDICAL SOCIOLOGY

Sociology of health, as a specialization within the discipline of sociology, began after World War II. Its initial growth resulted from the bourgeoning interest in

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health education. Indeed, in many ways, support for social research in health was a means of providing training and research funds for the vitalization of the broader discipline of sociology. Interest in the social aspects of health had been present since the eighteenth century in a variety of disciplines and in a number of countries. Social medicine, social hygiene, and public health developed most notably in France, Germany, and the United Kingdom. The strong growth of sociology of health in the 1950s can be traced to the enthusiasm and farsightedness of a few sociologists who were intent on modernizing sociology. It can also be traced to restless innovators and change agents within medicine who saw the need for a strong social science input into basic medical research, patient care activities, public health, and psychiatry. Well known sociologists who had made important contributions to the development of theory and research were able to provide support to the emerging specialization of medical sociology (e.g. Merton, 1965; Parsons, 1951). Established leaders in academic medicine, psychiatry, and public health (typically who had some experience collaborating with sociologists) are Merton and Reader, 1957; Hollingshead and Redlich,1958; Stanton and Schwartz, 1954.

In 1950, Donald Young tried to develop the role of social sciences in the development of health science from the sociological perspective. Simultaneously, he also made sure to expand health science in terms of establishing the schools of medicine, public health, and nursing schools. Many graduates of schools of health services administration, and programmes in management, public health administration, and health policy are trained conceptually and methodologically in ways that are commonplace in sociology departments.

3.3 SOCIOLOGICAL PERSPECTIVES ON HEALTH AND ILLNESS

Human development depends on health, an essential component for the well-being of mankind. An interaction of various social, economic, and political factors influence the health problems of community. The concepts of health, disease, and medicine are largely a product of post-nineteenth century scientific development. Ackerknecht (1942) commented that to the seventeenth century European, the American Indian Medicine would not have seemed strange and primitive in as much as cupping, bleeding, purging herbal remedies, some forms of surgery and even some exorcism, so also some of the associated beliefs and mystical theories about the causation of illness and the rules of healthy living would have been common to both. In the same vein, we may visualize the concepts of health and diseases of the slum dwellers who did not go to school as not significantly different from those of the so called rural people of India. This does not deny that some unique conceptions do not characterize the health concepts of individual rural people in different eco-historical cultural zones of India. While still on the problems encountered in developing satisfactory or adequate concepts we may have to

evolve the medically viable and bio-ecologically feasible indices to define various standards of normality in body temperature, blood pressure, and the physiological conditions.

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The concept of health has remained exclusive and difficult to define. Some people see health as a normal condition of the individual, others view it as opposite to illness, while some consider health as well developed and adequately nourished muscular body capable of doing work and able to withstand physical strain. Thus, health can also be considered the achievement of social and individual usefulness. The definition of health found in medical writings throughout the ages is broadly utopian. GIDEON, on healthcare in the second century, described health as a "condition of which we neither suffer pain nor are hindered in the function of daily life", that is when we are "able to take part in government, bathe and drink and eat, and do other things we want". Health is a state in which one is able to work without any difficulty. When work is hampered, then one will be called or designated as sick. Lieban (1977) stated that "health and diseases are measures of the effectiveness with which human groups combining biological and cultural resource adapt to their environment. Variations in health are connected with the variations in social circumstances and habit patterns".

Leslie (1976) said that there are some universal perceptions of health and disease and at the same time, there are also some perceptions unique to a particular society. Besides the unique socio-cultural systems and perceptions, environmental factors or conditions may also lead to differential spatial distribution of medical concepts. The cognition of health and disease, thus, in a cross-cultural perspective requires not only the biological explanation for the illness but also social, psychological, and religious explanation. We all think we know what 'health' is, but it is actually very difficult to define. When discussing healthcare it is important to realize that what people think as health can vary quite widely.

Health may be defined as the absence of diseases (i.e. negatively), or it can be simply defined as physical fitness. Another way to define health is in terms of what people are able to do (i.e. functionally), thus, health may be seen as 'optimal functioning' or the ability to do things.

It is customary to distinguish between both negative and positive definitions of health and functional and experimental definitions (Calnan, 1987). The medical view of health—the absence of disease— is clearly negative. An example of a positive definition by the World Health Organization (WHO) (1971) is "a state of complete physical, mental and social well- being and not merely the absence of disease and infirmity". However comprehensive, this has rarely been practicable. Well-being is defined as a harmonious relationship between an individual or group and the physical, biological and socio-cultural environment, as also feeling of satisfaction that is associated with this. More recently, WHO (2001) has indicated that health is a "cumulative state, to be promoted throughout life in order to ensure that the full benefits are enjoyed in later years". Good health is vital for maintaining an acceptable quality of life.

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A functional definition implies the ability to participate in normal social roles (Parsons, 1979), and this may be contrasted with an experiential definition which takes sense of self into account (Kelman, 1975).

Others have stated that health cannot be defined as a state because it is ever changing. Mckenzie et al. (2008), defined health as a dynamic state or condition of the human organism that is multidimensional (i.e. physical, emotional, social, intellectual, spiritual, and occupational) in nature, a resource for living, and results from a person's interactions with and adaptations to his or her environment. Therefore, it can exist in varying degrees and is specific to each individual and his or her situation.

For example, a person can be healthy just before dying, or a person with quadriplegia can be healthy in the sense that his or her mental and social well-being are high and physical health is as good as it can be (Hancock and Minkler, 2005). A person's health status is dynamic in part because of the many factors that determine one's health. It is widely accepted that health status is determined by the interaction of five domains: gestational endowments (i.e. genetic makeup), social circumstances (e.g. education, employment, income, poverty, housing, crime, and social cohesion), environmental conditions where people live and work (i.e. toxic agents, microbial agents, and structural hazards), behavioural choices (e.g. diet, physical activity, substance use and abuse), and the availability of quality of care (McGinnis, 2001).

The health of each one of us is determined by factors acting not mostly in isolation but by our experience where the domains interconnect. The expression of a gene can be determined by environmental exposures or behavioural patterns. Social circumstances affect the nature and consequences of behavioural choices which in turn affects the health care we receive. (McGinnis et al. 2002)

Another approach to defining health is the examination of people's perceptions of the concept. For example, in a study if elderly people in Aberdeen, Williams (1983) identified three lay concepts of health from his interview data: health is an absence of disease; health as a dimension of strength, weakness and exhaustion; and health as functional fitness.

These three conceptualizations broadly parallel those deciphered by Herzlich (1973) in her interviews with 80 middle class people living in Paris and rural Normandy a decade earlier. Herzlich identified 'health as a vacuum'—which implies an absence of disease; 'reserve of health'—a biological capacity to resist or cope with illness which increases or decreases over time; and 'equilibrium' which is normal health, rarely attained. Empirical studies have found that people's ideas are likely to incorporate a number of these dimensions. However, there is evidence to suggest some relationships between types of beliefs and social location. For example, d'Houtard and Field (1984), in a study of 4000 people in France, found that non-manual respondents had more positive and personalized conceptualizations of health, whereas manual respondents revealed negative and instrumental

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definitions. In the UK, research has found that working-class women are more likely to hold functional conceptualizations of health (Blaxter and Peterson, 1982; Pill and Scott, 1982) which may be linked to material constraints and situations in which they have little choice but to fulfill their social obligations. A secondary analysis of Blaxter's data to examine the comparative health beliefs of Asian, Afro-Caribbean and White respondents, Asians were more likely to define health in functional terms and Afro-Caribbeans were more likely to describe health in terms of energy and physical strength. They were also more likely to attribute illness to bad luck.

This supports Donovan's (1986) findings that groups in society with the least power are more likely to hold fatalistic views on illness causation.

The concept of health is difficult to define and measure. Although we associate it with the activities of doctors, it is only indirectly linked to medical treatment. Doctors deal primarily with disease and not with the promotion of health in any positive way. The knowledge of medicine is a catalogue of disorders implying that when any one disease or disorder is present people are considered to be ill. But to promote health involves the prevention of disease, not merely its treatment. Given that limited scope exists to restore or repair damaged health, there is little to learn about health as such in medical literature. So, what is health and what are the factors that protect it or put it at risk? At a personal level, we all know the answer, at least, to the first of these questions. We know from personal experience of feeling well and feeling ill how to distinguish health and ill-health in subjective terms. But converting subjective knowledge into a standard measure which applies to the whole population is by no means easy. To begin with, not everybody has the same threshold of pain or the same expectations about what counts as abnormal symptoms. Some people go to the doctor for complaints which others may not even notice and yet the latter include people who spend a whole lifetime apparently feeling healthy only to die at an early age of a preventable or treatable condition. The problem is finding a definition for health which covers these variations and permits the measurement of health experience in the population as a whole. The definition was adopted by WHO in June, 1946. Representatives of 61 states conferred to this definition and since then this definition has not been amended.

This definition emphasizes the interdependence of physical and mental welfare stressing that feeling well is not just a physical experience. But how can these different dimensions be converted into a measure which can be used to study the distribution of health in one society or compare standards of health between societies? In the absence of any universally valid measure, most surveys of health rely on one or other of the health status indicators of **morbidity** and **mortality**. The first of these, morbidity, which means sickness or diseased state of the individual, is an indicator not of health but of its absence. It is measured either through self-reported illness in health surveys or from the statistics of time off work. Alternatively, it may be constructed from the records of consultation between doctors and patients. The statistics of morbidity in any of these forms represent

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health negatively as a state of illness at one point in time. As such they tend to convey the impression of ill health in episodic terms as something that happens suddenly and then goes away, rather than as a continuous dimension of experience. They also pose a number of problems of interpretation when applied for the purposes of comparing health experience within a population. Self-reported sickness has the shortcomings, already mentioned, of being based on subjective judgement. Thus of statistics of absence of sickness can only present the experience of people at work, while those of medical treatment are as much a measure of availability of, as demand for, services. Mortality (susceptibility to death), is a measure of health constructed from mortality statistics. It can provide information about risk of death at any age and from any particular cause. Its great limitation is that it only represents forms of ill-health that are ultimately fatal and not all those other forms of pain and suffering that do not result in loss of life. However, it is not influenced by the processes of subjective judgement in the way that morbidity is and, being a more objective judgement it can be used to study changes over time. In fact the incidence of mortality is the only means of studying health in earlier periods.

Age at the time of death provides a measure of the length of the human lifetime. It indicates, in other words, the durability of the human body, the time it takes to wear out. In this sense, mortality is a particularly a useful indicator. It captures the positive dimension of health and avoids the trap of presenting ill health as an episodic event. Life expectation is the only means of making any sense of what people's health was like in the nineteenth century and before. Health is the unity and harmony between the mind, body, and spirit. This is unique to each person and is as defined by that person. The level of wellness or health is partly determined by the ability to deal with and defend against stress. Health is a continuum between a state of optimum well-being and illness which is defined as degrees of disharmony. It is determined by physiological, psychological, socio-cultural, spiritual, and developmental stage variables. An understanding of health is the basis of all healthcare. Health is perceived differently by all members of a community which includes various professional groups (e.g. biomedical scientists, social science specialists, health administrators, and ecologists).

Society is dynamic, the changes in the structures, processes, modifications and changes occur in the concepts also. The concept of health is also dynamic. New patterns of thought and philosophy emerge in the concept of health. The concept of health originated from time immemorial, with the result that the focus has shifted from individual to community, to ethnic groups and international level which encompasses the whole quality of life. The changing concept of health is outlined in the subsequent pages.

Biomedical Concept

Earlier, the concept of health was viewed in terms of absence of disease. The whole notion of biological concept of health is based on the germ theory. Germ theory of disease was a dominant one at the turn of twentieth century. Scientists

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were looking for the causes of diseases in relation to germs and ignoring all the other factors. Medical profession views the human body as a machine and points out that failure or obstruction in the machine causes the disease. The task of the doctor is to repair the obstruction or failure of the machine. Thus, this concept of health made the definition of health quite narrow and ultimately left to the rescue of medicine and health professionals. However, health viewed in the form of biomedical theory has minimized the role of environmental, social, psychological, and cultural determinants of health. The biomedical model of disease which is based on scientific criteria could not find adequate answers in finding the solution for poverty, malnutrition, chronic diseases, mental illnesses, environmental pollution, drug abuse and accidents and population explosion by elaborating the medical technologies. Developments in medical and social sciences led to the conclusion that the biomedical concept of health was inadequate.

Ecological Concept

The criticism levelled against biomedical concept of health gave rise to the ecological concept of health. Ecologists viewed health in terms of dynamic equilibrium between man and his environment and disease maladjustment of the human organism to environment. Dubos (1965) defined health in the environmental paradigm and asserts that heath implies the relative absence of pain and discomfort, continuous adaptation and adjustment to the environment to ensure optimal function. Human ecological and social-cultural issues are so important that they determine the occurrence of the disease but at the same time also determine the availability and population problem. Ecology is mainly concerned with two aspects, i.e. man and environment. It can also be explained that if a man is imperfect it means the environment is also imperfect. History is witness to the argument that improvement in human adaptation to natural environment can lead to longer life expectancies and a better quality of life even in the absence of modern health delivery system (WHO, 1986).

Psychosocial Concept

Continuous development in social sciences has revealed that health is not only a biomedical phenomenon but is also influenced by social, political, economic, cultural, and psychological factors. Thus, we conclude that health is not only a biological but social phenomenon.

Holistic Concept

The holistic model is the integration of all the above concepts. It gives due importance to social, economic, political, and environmental factors for influencing health. It has been defined as an integrated or unified process involving the well-being of a person in relation to his/her environment. In ancient times, health meant a sound mind in a sound body in a sound family in sound environment. The holistic

approach of health recognizes that different sectors of society namely agriculture, animal husbandry, water and sanitation, housing, communication, forestry and public works share the concern for health. Thus, overall the emphasis is on the promotion and protection of health.

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Critique of Definition of Health

The definition of health promulgated by WHO has been critically evaluated. The critics argue that this definition is very idealistic and does provide space but is not flexible. The critics are also uncomfortable with the word 'complete' as they find it is an imaginative idea that one will be completely free from all worries and without any disease or infirmity. It is unlikely that anyone would be healthy throughout his/ her life. It is also argued that a state of complete state of physical, mental and well-being is closer to happiness than to health (Bircher, 2005). Bircher further argues that the words health and happiness show different life experiences, where the relationships are neither fixed nor constant. It implies that if one is not able to distinguish between happiness and health and if happiness is not there, it means health problems. Bircher's emphasis is on changing health needs, especially in relation to age, and personal responsibility. Health Belief Model is also another perspective which examines the meaning of health. Becker's (1974) Health Belief Model explains the concept of health perceived by individual and groups. It is analyzed exclusively in the non-religious groups and able to understand the perception of people in understanding ill-health (Golub, Bur, and Cromin, 2005). Health Belief Model includes culture, age, and personal responsibility. It ultimately helps in understanding the subjective concept of health and ill-health.

What is the meaning of health in the twenty-first century? Sarrachi (1996) provides an alternative to the concept of health by including the emerging issues of human rights, equity, and justice to the definition of health given by WHO. Thus, we conclude that the definition of health can be modified by adding certain valuable concepts of health emerging in the contemporary society to enrich a more broad definition.

New Philosophy of Health

In contemporary times, new philosophies of health have surfaced.

- Health is regarded as a fundamental human right.
- Health is regarded as an essence of productive life and minimizing the expenditure on medical care.
- Health is not in isolation rather it is inter-sectoral and regarded as an essential component of social development.
- Health is the focal point of quality of life.
- It is regarded that health is not only the concern of the individual, but also the responsibility of state and international society.

- Investment in health is investment for society and its development.
- Health is a worldwide and global phenomenon.

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Sociology of Illness

Disease, as defined by doctors, is an abnormal condition affecting the body of an organism and is based upon the observation of biological pathology. The conception of disease is 'objective', 'scientific' and based on the biomedical model of pathology which is the basis of modern medical thought. In contrast to the 'objective view of disease, the concept of illness refers to the person's subjective experience of ill health. It goes beyond the biological and physical consequences of disease, affecting the person's subjective well-being and their social functioning. Illness is recognized by departures from the person's normal state of being and by altered feelings which may be diffuse.

To be ill, then, is not simply to be in a physically altered state, but also to be in a society altered condition which is normally disruptive of everyday life and is undesired. Illness is both personal and social. The individuals who feel ill are likely to talk to others in their attempts to make sense of their physical symptoms and feelings of 'disease' and departure from normal functioning. While they may draw upon biomedical ideas and knowledge to make sense of their illness, people also use other ideas which are current in their social groups both to make sense of their illness and to decide what action, if any, should be taken. For example, ideas of what constitutes 'flu', how to recognize it, and how to treat it (feed a cold, starve a fever). Such 'lay theories' of illness may be complex and detailed, and provide explanations which link the experiences of illness to the personal and social circumstances of the ill person in ways which may be more consistent and believable to them than professional medical explanations.

Relationship of Health and Illness

Cornwall's qualitative study of east Londoners (1984) shows the way in which general perceptions of health (level of functional or metabolic efficiency of a living being) and illness (poor health resulting from disease of body or mind) as 'matters that are largely beyond the control of individual reflect ideas and experiences other than areas such as paid work'. These general perceptions are broadly based upon medical ideas and in everyday life are modified by taking account of the individual circumstances (e.g. the nature of work) and characteristics (e.g. the weak constitution) of individuals. People also differentiated between whether illnesses were 'normal' (infectious diseases), 'real' (disabling and life-threatening diseases) or 'health problems which are not illness' but which are linked to natural processes such as ageing or reproduction. It was also recognized that not all illnesses were treatable. Donovan (1986) similarly shows how the health beliefs of Afro-Caribbeans and Asians linked their health behaviour their life situations and cultural beliefs. For example, in both groups of respondents, diet was seen as

linked to health and illness, and use of remedies such as herbal teas or 'hot' and 'cold' foods was part of their cultural beliefs and world view. Among Asians, dietary practices were also linked to religious beliefs and practices.

3.3.1 The Sick Role

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Another unique contribution of sociology of health has been the study of the 'sick role', which expanded into a broader study of illness experience. This area includes the social role of the patient, illness behaviour, illness/patient careers, and the ways that these factors shape and are shaped by doctor-patient interaction. Talcott Parson's (1951) work on the sick role was the foundation for the sociological examination of illness and the expectations placed on those who are ill. Mechanic (1962) worked on illness behaviour. Medical anthropologists have long studied illness in part as a way to examine the values in a society or group in the face of uncontrollable events, sociologists brought a greater interest in the impact of role expectations, norms, and sanctions, and the accommodations or lack thereof for the needs of those with illnesses or disabilities. This work includes rich ethnographic studies of illness experiences (e.g., Roth and Conrad, 1987; Charmaz, 1991), as well as research on factors affecting the decisions to seek care (Berkanovic, Telesky, and Reeder, 1981), and patterns of healthcare utilization (Mechanic, Cleary, and Greenly, 1982).

Check Your Progress

1. What can the strong growth of sociology of health in the 1950s be traced to?
2. How can health be defined?
3. How did Herzlich identify health?
4. What is the limitation of the term 'mortality'?
5. What has continuous development in social sciences revealed?
6. What does the holistic approach of health recognize?

3.4 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The strong growth of sociology of health in the 1950s can be traced to the enthusiasm and farsightedness of a few sociologists who were intent on modernizing sociology. It can also be traced to restless innovators and change agents within medicine who saw the need for a strong social science input into basic medical research, patient care activities, public health, and psychiatry.

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2. Health may be defined as the absence of diseases (i.e. negatively), or it can be simply defined as physical fitness. Another way to define health is in terms of what people are able to do (i.e. functionally), thus, health may be seen as 'optimal functioning' or the ability to do things.
3. Herzlich identified 'health as a vacuum'—which implies an absence of disease; 'reserve of health'—a biological capacity to resist or cope with illness which increases or decreases over time; and 'equilibrium' which is normal health, rarely attained. Empirical studies have found that people's ideas are likely to incorporate a number of these dimensions.
4. The great limitation of the term 'mortality' is that it only represents forms of ill-health that are ultimately fatal and not all those other forms of pain and suffering that do not result in loss of life.
5. Continuous development in social sciences has revealed that health is not only a biomedical phenomenon but is also influenced by social, political, economic, cultural, and psychological factors.
6. The holistic approach of health recognizes that different sectors of society namely agriculture, animal husbandry, water and sanitation, housing, communication, forestry and public works share the concern for health. Thus, overall the emphasis is on the promotion and protection of health.

3.5 SUMMARY

- Sociology of health, as a specialization within the discipline of sociology, began after World War II. Its initial growth resulted from the bourgeoning interest in health education.
- The strong growth of sociology of health in the 1950s can be traced to the enthusiasm and farsightedness of a few sociologists who were intent on modernizing sociology. It can also be traced to restless innovators and change agents within medicine who saw the need for a strong social science input into basic medical research, patient care activities, public health, and psychiatry.
- Ackerknecht (1942) commented that to the seventeenth century European, the American Indian Medicine would not have seemed strange and primitive in as much as cupping, bleeding, purging herbal remedies, some forms of surgery and even some exorcism, so also some of the associated beliefs and mystical theories about the causation of illness and the rules of healthy living would have been common to both.
- The cognition of health and disease, thus, in a cross-cultural perspective requires not only the biological explanation for the illness but also social, psychological, and religious explanation.

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- The medical view of health—the absence of disease— is clearly negative. An example of a positive definition by the World Health Organization (WHO) (1971) is "a state of complete physical, mental and social well- being and not merely the absence of disease and infirmity".
- A functional definition of health implies the ability to participate in normal social roles (Parsons, 1979), and this may be contrasted with an experiential definition which takes sense of self into account (Kelman, 1975).
- It is widely accepted that health status is determined by the interaction of five domains: gestational endowments (i.e. genetic makeup), social circumstances (e.g. education, employment, income, poverty, housing, crime, and social cohesion), environmental conditions where people live and work (i.e. toxic agents, microbial agents, and structural hazards), behavioural choices.
- In the UK, research has found that working-class women are more likely to hold functional conceptualizations of health (Blaxter and Peterson, 1982; Pill and Scott, 1982) which may be linked to material constraints and situations in which they have little choice but to fulfill their social obligations.
- Mortality (susceptibility to death), is a measure of health constructed from mortality statistics. It can provide information about risk of death at any age and from any particular cause.
- The concept of health originated from time immemorial, with the result that the focus has shifted from individual to community, to ethnic groups and international level which encompasses the whole quality of life. The changing concept of health is outlined in the subsequent pages.
- The whole notion of biological concept of health is based on the germ theory. Germ theory of disease was a dominant one at the turn of twentieth century. Scientists were looking for the causes of diseases in relation to germs and ignoring all the other factors.
- Human ecological and social-cultural issues are so important that they determine the occurrence of the disease but at the same time also determine the availability and population problem.
- Health Belief Model explains the concept of health perceived by individual and groups. It is analyzed exclusively in the non-religious groups and able to understand the perception of people in understanding ill-health (Golub, Bur, and Cromin, 2005). Health Belief Model includes culture, age, and personal responsibility.
- Health is not in isolation rather it is inter-sectoral and regarded as an essential component of social development.

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- The conception of disease is 'objective', 'scientific' and based on the biomedical model of pathology which is the basis of modern medical thought. In contrast to the 'objective view of disease, the concept of illness refers to the person's subjective experience of ill health. It goes beyond the biological and physical consequences of disease, affecting the person's subjective well-being and their social functioning.
- Another unique contribution of sociology of health has been the study of the 'sick role', which expanded into a broader study of illness experience. This area includes the social role of the patient, illness behaviour, illness/patient careers, and the ways that these factors shape and are shaped by doctor-patient interaction.

3.6 KEY WORDS

- **Morbidity:** It is any physical or psychological state considered to be outside the realm of normal well-being. The term is often used to describe illness, impairment, or degradation of health.
- **Sick Role:** It is a theory in medical sociology that was developed by Talcott Parsons. It is a concept that concerns the social aspects of becoming ill and the privileges and obligations that come with it.

3.7 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. How has GIDEON described health?
2. Give an example of a positive definition of health.
3. How did Mckenzie et al define health?
4. Write a short note on morbidity.
5. Write a short note on the concept of illness.

Long-Answer Questions

1. Discuss the historical development of medical sociology.
2. Elaborate upon the difficulties of defining and measuring the concept of health.
3. Analyze the biomedical concept of health.
4. Examine the relationship of health and illness.

3.8 FURTHER READINGS

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BLOCK - II
CONCEPT OF HEALTH AND ILLNESS, FORMATION OF HEALTH BEHAVIOUR, SOCIAL MEDICINE, THEORETICAL PERSPECTIVES OF HEALTH

UNIT 4 CONCEPT OF HEALTH AND ILLNESS

Structure

4.0 INTRODUCTION

Health refers to a state of physical, mental and social well-being where diseases and illness are absent. In order for an individual to be healthy, five dimensions are taken into consideration. These dimensions are: physical, social, intellectual, spiritual and emotional. A healthy body and mind are essential for an individual to attain his goals and reach his highest potential in terms of work done for his own growth or for the betterment of society. The aforementioned dimensions have been discussed in this unit.

4.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the physical, social and mental dimensions of health
- Analyze the spiritual, vocational, intellectual, emotional and other dimensions of health
- Understand the dimensions of health among the elderly population

4.2 ASPECTS OF HEALTH: PHYSICAL, SOCIAL, EMOTIONAL AND SPIRITUAL

Good health or a healthy life is composed of five dimensions, namely: physical, intellectual, emotional, social, and spiritual. These good health parameters were advocated by WHO while defining the concept of health and are ratified by the participant countries. Mind and body are so closely related with each other that disturbance in one part sends the message and is exhibited in the form of symptoms. These symptoms are in a way a non-functional activity of the bodily organs. There are various procedures to read these symptoms with a variety of instruments as well as with non-performance of activity of organs in the body. Therefore, it is important to understand and read the symptoms of body and to ensure the balance of mind, spirit, and body.

This integration puts health in the format of multidimensionality. With the passage of time, many more dimensions have been added in understanding the composite nature of health. The additional dimensions are emotional, vocational, intellectual, and political. These dimensions also interact with one another. One can also assume that with the further passage of time many more dimensions may be added.

Physical Dimensions of Health

There is a direct relation between the physical dimension of the health and the perfect functioning of the body. It is related to the functioning of the body cells and organs at the optimum level. There is ambiguity in defining the optimum level of functioning. Physical health is viewed in terms of colour of the skin, height and body weight and other physical features by some individuals.

Many sociological studies have been exclusively done on the concept of health and definition of health. The concept of health is visualized in the form of bright eyes, good appetite, a sound sleep, capacity to do hard work and no fatigue even after doing hard work. They also view health in terms proper functioning of different body parts and the sense organs. Physical dimension of health also includes normal pulse rate and normal blood pressure. Young and growing individuals require much more vigour of the organs to help them in the growth of their physical bodies. Optimal height and weight are debatable issues and according to many bio-sociological studies height and weight varies according to ethnicity, culture, and ecological conditions. There are a number of ethnic communities where people are shorter in height but they are equally healthy as others. Thus, we conclude that physical health refers to the state of the body, its composition, development, functions, and maintenance of its vital organs. Since health is related with the functioning and maintenance of the body organs, it is necessary to keep ourselves

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healthy by doing physical exercises, and eating nutritious food. The balance of nutrients in the body is essential for maintaining good health. Imbalance results in ill-health, hence, it is necessary to go for medical check-up and follow the rules prescribed by the doctors.

Modern medicine has evolved tools and techniques which may be used in various combinations for the assessment of physical health. They include:

- self-assessment of overall health
- symptoms of ill health and risk factors
- medication
- levels of activity (e.g. number of days of restricted activity within a specified time, degree of fitness)
- use of medical services (e.g the number of visits to a physician, number of hospitalizations) in the recent past
- standardized questionnaires for respiratory diseases
- clinical examination
- nutrition and dietary assessment
- biochemical and laboratory investigations

At the community level, the state of health may be assessed by such indicators as death rate, mortality rate, and life expectation. Ideally, each piece of information should be individually useful and when combined should permit a more complete health profile of individuals and communities.

Mental Dimension

Mental health is not merely absence of mental illness. Good mental health is the ability to respond to the many varied experiences of life with flexibility and a sense of purpose. More recently, mental health has been defined as "a state of balance between oneself and others, a co-existence between the realities of the self and that of other people and of the environment, (Sartorius, 1983).

Some decades ago, the mind and body were considered independent entities. However, researchers have discovered that psychological factors can induce all kinds of illness, not simply mental ones. They include conditions such as essential hypertension, peptic ulcer, and bronchial asthma (WHO, 1964). Some major illnesses such as depression and schizophrenia have a biological component. The underlying inference is that there is behavioural, psychological or biological dysfunction and that the disturbance in the mental equilibrium is not merely in the relationship between the individual and society.

Although mental health is an essential component of overall health, the scientific foundations of mental health are not yet clear. Therefore, precise tools to

assess the state of mental health are not available. Attributes of a mentally healthy person are:

- free from internal conflicts; he/she is not at 'war' with himself/herself
- well adjusted, i.e. he/she is able to get along well with others
- accepts criticism and is not easily upset
- searches for an identity
- a strong sense of self-esteem
- knowledge of one's needs, problems and goals (this is known as self-actualization)
- good self-control with balance between rationality and emotionality
- faces problems and tries to solve them intelligently, i.e. coping with stress and anxiety

Assessment of mental health at the population level may be made by administering mental status questionnaire by trained interviewers.

Social Dimension

Man is a social animal. He/she is surrounded by a network of social relationships. These relationships are reciprocal and satisfy various needs in the society. Various ideas and interactions take place and, therefore, we also share our emotions. There are diverse cultures in the society and these cultures are regulated by various norms and practices. Although, these cultures are different, they are shared by community people and cultural diffusion also takes place. The normal individual is a part of all these functions and he/she is capable of sharing the traits of culture and maintaining harmony. This sharing process builds a positive image and enhances the interpersonal communication skills. It is necessary to be involved in the community as well as in the society at large. The more a person is involved in the process of integration, more he/she is regarded as a healthy person. Thus, the social dimension of the health includes the level of social skills, social functioning of the individual and one's ability to see one self as a member of the whole society. Overall the social dimension of health is primary related with the individual as a family member, he/she is part of society and above all he/she is member of larger group. It also focuses on social and economic conditions and well-being of the society which is ultimately related with the network of social relationships. Fillenbaum has pointed out the importance of positive human environment and positive material environment which is in turn related with the social network and financial and material conditions of the individual.

Spiritual Dimension

Besides being a social being, spiritualism is also necessary a part of a healthy life. One has goals in life and one strives to achieve these goals. A spiritual person sets

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his/her own meanings, personal beliefs, his/her own acceptance or rejection of the creation. Spiritualism is related with one's inner self, therefore, there are no objective meanings attached to it. There are no universal laws which define the method of goal attainment, rather it is one's own understanding of existence and creation. This is a new dimension which is important in the present society as life has become very complex. To get released from these complexities, one needs to have spiritualism which in turn affects health. The thought of spiritualism directs the mind to think or reach out for the constructive meaning of life. The worth in life ultimately transcends into good physical well-being and a healthy life. This is not an old philosophy of health, rather it has emerged in the contemporary times. In short, spiritualism includes integrity, principles, ethics, and the purpose in life. It also includes commitment to some higher being.

Emotional Dimension

Emotional dimension of health is the domain under psychology. Human beings are social beings and emotional beings. Therefore, emotional elements are indispensable from a healthy human being. Emotional well-being is the ability in the human being to adjust and cope with our own and others feelings. Emotions are present in all human beings and vary in different periods of time and in different situations. They require a course of action to cope with them. Emotions are present in pleasant situations and in despair. Many times emotions are visible, but in certain situations such as depression, and anxiety they are not easily visible and can lead to mental illness which ultimately affects the health. Therefore, one should be aware of one's weaknesses and strengths which can be helpful in coping from emotionally disturbing situations. One can seek help so that the situation can be altered. Further, it can be altered by building a strong cushion of relationships with the family, peer groups, and community. Plenty of research is done on mental health, which concludes that absence of emotional security leads to the illness. Emotional health is related to one's feelings whereas mental health can be seen as 'knowing' or 'cognition'. The people who are working on mental health and emotional health may be able to separate them cognitively. Thus, in the present times, the mental and emotional aspects of human beings should be viewed separately particularly in the context of human health.

Vocational Dimension

Vocational dimension is related with the work one does. Every human being who has come in the world is supposed to do some or other type of work. Work should be adaptable according to human capacity. Work also depends on one's limitations to perform. The performance of work is directly related to the physical and mental health of the individual. Physical work is related with one's capacity to perform, while its goal is associated with self-realization of satisfaction and enhanced self-esteem. Its actual potential is realized only when the person is without work

or out of work or may be retired. This situation immediately affects his/her health. People think that vocational dimension is related with the economic aspects or it is valued in the form of a source of income, but it represents the persons' ability in the form of success to prove his/her worth in the society and not become a burden on others.

Intellectual Dimension

Intellectual dimension is related with one's ability to develop skills and knowledge to make life more meaningful. Intellectual capacity gives ability to think rationally and in turn translates it into the idea of creativity and insight in decision making. One can plan things in such a manner that will go a long way and will make life successful. The mind is able to think with openness and act accordingly. It will not be influenced by any subjectivity or other external pressure to influence your decision. Additionally, positive intellectual thinking will automatically contribute to good health. It is also helpful in the conflicting situations for arriving at the rational arguments.

Other Dimensions

A few other dimensions are also important while discussing health. These are: philosophical, cultural, socio-economic, environmental, educational, nutritional, curative and preventive.

A glance at these dimensions shows that there are many non-medical dimensions of health that are equally important for the purpose of health.

Dimensions of Health among the Elderly Population

Researchers have attempted to combine indicators of health of the elderly into a single summary measure, but these summaries are generally ad hoc and lacking in nuance. The most common single measure of disability is whether the person has any impairments in Basic Activities of Daily Living (BADL), such as bathing or dressing or Instrumental Activities of Daily Living (IADL), such as doing light housework or managing money.

Cutler and Leandrum (2011) characterize the multi-faceted health of the elderly and describe how health has changed over time across many dimensions. Data from the Medicare Current Beneficiary Survey, collected from 1991-2007, shows that nineteen measures of health can be combined into three broad categories: the first dimension representing severe physical and social incapacity such as difficulty in dressing or bathing; a second dimension representing less severe difficulty such as walking long distances or lifting heavy objects; and a third dimension representing vision and hearing impairment. These dimensions have changed at different rates over time. The first and third have declined rapidly over time, while the second has not. The improvement in health is not due to differential mortality of the sick or a new generation of more healthy people entering old age. Rather, the ageing process itself is associated with less rapid deterioration in health.

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Check Your Progress

1. What are the five dimensions of good health?
2. How is the concept of health visualized?
3. List five attributes of a mentally healthy person.
4. Why should the emotional and mental aspects of human beings be viewed separately?
5. What is the most common single measure of disability?

4.3 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. Good health or a healthy life is composed of five dimensions, namely: physical, intellectual, emotional, social, and spiritual.
2. The concept of health is visualized in the form of bright eyes, good appetite, a sound sleep, capacity to do hard work and no fatigue even after doing hard work.
3. The attributes of a mentally healthy person are:
   - free from internal conflicts; he/she is not at 'war' with himself/herself
   - well adjusted, i.e. he/she is able to get along well with others
   - accepts criticism and is not easily upset
   - searches for an identity
   - a strong sense of self-esteem
4. Emotional health is related to one's feelings whereas mental health can be seen as 'knowing' or 'cognition'. The people who are working on mental health and emotional health may be able to separate them cognitively. Thus, in the present times, the mental and emotional aspects of human beings should be viewed separately particularly in the context of human health.
5. The most common single measure of disability is whether the person has any impairments in Basic Activities of Daily Living (BADL), such as bathing or dressing or Instrumental Activities of Daily Living (IADL), such as doing light housework or managing money.

4.4 SUMMARY

- Good health or a healthy life is composed of five dimensions, namely: physical, intellectual, emotional, social, and spiritual. These good health

parameters were advocated by WHO while defining the concept of health and are ratified by the participant countries.

- With the passage of time, many more dimensions have been added in understanding the composite nature of health. The additional dimensions are emotional, vocational, intellectual, and political. These dimensions also interact with one another.
- There is a direct relation between the physical dimension of the health and the perfect functioning of the body. It is related to the functioning of the body cells and organs at the optimum level.
- The balance of nutrients in the body is essential for maintaining good health. Imbalance results in ill-health, hence, it is necessary to go for medical check-up and follow the rules prescribed by the doctors.
- Mental health is not merely absence of mental illness. Good mental health is the ability to respond to the many varied experiences of life with flexibility and a sense of purpose. More recently, mental health has been defined as "a state of balance between oneself and others, a co-existence between the realities of the self and that of other people and of the environment, (Sartorius, 1983).
- Some major illnesses such as depression and schizophrenia have a biological component. The underlying inference is that there is behavioural, psychological or biological dysfunction and that the disturbance in the mental equilibrium is not merely in the relationship between the individual and society.
- There are diverse cultures in the society and these cultures are regulated by various norms and practices. Although, these cultures are different, they are shared by community people and cultural diffusion also takes place. The normal individual is a part of all these functions and he/she is capable of sharing the traits of culture and maintaining harmony.
- Overall the social dimension of health is primary related with the individual as a family member, he/she is part of society and above all he/she is member of larger group. It also focuses on social and economic conditions and well-being of the society which is ultimately related with the network of social relationships.
- A spiritual person sets his/her own meanings, personal beliefs, his/her own acceptance or rejection of the creation. Spiritualism is related with one's inner self, therefore, there are no objective meanings attached to it.
- Plenty of research is done on mental health, which concludes that absence of emotional security leads to the illness. Emotional health is related to one's feelings whereas mental health can be seen as 'knowing' or 'cognition'.
- The performance of work is directly related to the physical and mental health of the individual. Physical work is related with one's capacity to

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perform, while its goal is associated with self-realization of satisfaction and enhanced self-esteem. Its actual potential is realized only when the person is without work or out of work or may be retired.

- Data from the Medicare Current Beneficiary Survey, collected from 1991-2007, shows that nineteen measures of health can be combined into three broad categories: the first dimension representing severe physical and social incapacity such as difficulty in dressing or bathing; a second dimension representing less severe difficulty such as walking long distances or lifting heavy objects; and a third dimension representing vision and hearing impairment.

4.5 KEY WORDS

- **Schizophrenia:** It is a long-term mental disorder of a type involving a breakdown in the relation between thought, emotion, and behaviour, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation.
- **Self-Actualization:** It is the highest level of psychological development where the "actualization" of full personal potential is achieved, which occurs usually after basic bodily and ego needs have been fulfilled.
- **Cognition**: It refers to the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses.
- **Basic Activities of Daily Living (BADL):** The basic ADLs (BADL) or physical ADL are those skills required to manage one's basic physical needs including personal hygiene or grooming, dressing, toileting, transferring or ambulating, and eating.

4.6 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. How is physical health viewed?
2. List some tools and techniques which may be used in various combinations for the assessment of physical health.
3. How can the state of health be assessed at the community level?
4. What do the social dimensions of health include?
5. Write a short note on the intellectual dimension of health.

Long-Answer Questions

1. Discuss the physical dimension of health.
2. Elaborate upon the social dimensions of health.
3. Analyze the dimensions of health among the elderly population.

4.7 FURTHER READINGS

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UNIT 5 FORMATION OF HEALTH BEHAVIOUR

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Structure

5.0 INTRODUCTION

A lot of people have different opinions and views when it comes to health. Some are of the opinion that when someone is free from all diseases per se then that person is supposedly healthy and fit. Whereas on a similar pattern, others are of the view that is a person is able to perform his daily chores without any hindrance then that person is said to be healthy and some are of the opinion that when a person is able to do various activities, no matter how difficult the situation, one is healthy. Health is not just a medical concept but it is a social construct as well. In this unit, the changing concepts of health, the models of health and illness and models of health behaviour have been analyzed.

5.1 OBJECTIVES

After going through this unit, you will be able to:

- Analyze the social construction of health
- Discuss the changing concepts, dimension and determinants of health
- Describe the models of health and illness
- Understand the theoretical models of health behaviour and indicators of health

5.2 BELIEFS, VALUES, ATTITUDES AND PRACTICES, SOCIAL GROUP AND ACCESS TO HEALTHCARE

According to the National Health Policy (1982), appropriate communication strategies provide us with health information in an understandable form for forming up of an attitude necessary for a healthy living.

Let us look at the definition of what is meant by health:

1. A successful and ongoing adaptation to environment.
2. According to Webster dictionary, health refers to those conditions and environment whereby one is sound in body mind as well as in spirit and further one is free of any sort of physical diseases.
3. According to Oxford dictionary, health refers to soundness and wellness of mind and body.
4. Perkin has defined health as follows: "A state of relative equilibrium of body, form and function which result from its successful dynamic adjustment to forces tending to disturb it. It is not passive interplay between body substance and forces impinging upon it but an active response of body forces working towards readjustment."

Let us now look at the definition given by WHO (World Health Organization) which states clearly that "Health is a state of complete physical, mental, social and spiritual wellbeing and not merely an absence of disease or infirmity".

Social Construction of Health

Medical sociology is seen as the systematic study of how human beings manage issues of health and illness, disease and health care for both the sick as well as for the healthy ones. First the whole conception of social construction of health did not seem to have made sense at all. But later on, its importance was seen. The idea of the social construction of health emphasizes the socio-cultural aspects of the discipline's approach to physical, objectively definable phenomena.

Health behaviour: health behaviour refers to those actions which are taken by a person which affect the health. The actions can be done deliberately or unintentionally. There are many actions of an individual which can be labelled as health behaviours that include smoking, diet, physical diet, sleeping, etc. Health behaviours of an individual concerned are discussed as individual-level behaviours. They are found to be dynamic which varies over the lifespan and across time. For instance if we talk about smoking in USA per se, we find that the likelihood of initiation varies with age.

Changing Concepts of Health

Health is found to be a common theme in many nations and countries worldwide. Earlier, the most simple and well known definitions of health simply referred to an absence of any kind of disease. Further, the idea of mental health which in today's time is so common and used all over the world, did not exist earlier.

1. **Biomedical Concept of health:** In earlier times, health was viewed as "absence of any sort of diseases". If any human being doesn't contain in him/her any sort of diseases then the person is labeled as healthy. This concept is known as "Biomedical Concept".
2. **Ecological Concept of health:** the Ecological Concept of health tends to view health as a dynamic equilibrium which takes place between man and his environment and it views diseases as a maladjustment of the human organisms. It further believes that in order to protect oneself from unhealthy factors we need clean air, water and so on.
3. **Psychosocial Concept of health:** In today's current times, health is seen as to be both a biological and social phenomenon simultaneously.
4. **Holistic Concept of health:** it is an amalgamation of biomedical & ecological model & psychosocial concept.

Models of Health and Illness

Let us look at the models of health and Illness which are as follows;

1. **Health-Illness Continuum Model:** Health is always found to involve a continuum. It means in simple terms that health of any person moves back and forth along a particular continuum. According to this model, we find that they find health to be a dynamic state which fluctuates and changes as an individual adapts and fits itself to the changing environment be it either internal or external environment. The former refers to the physiological system, body temperature and so on while the latter refers to the atmospheric temperature, humidity, dust, and so on.
2. **High-Level Wellness Model:** The high-level wellness model was developed and formulated by Halpert Dunn (1977). This model tends to look at maximizing the health potential of an individual, family or community. Its requirement lies in the sense that the person needs to maintain a good amount of balance that is a continuum of balance needs to be maintained within the environment. According to Halpert Dunn, high-level wellness is defined as the following an integrated method of functioning which is oriented towards maximizing the potential of which an individual is capable within the environment where he is functioning"
3. **Health Belief Model:** It was formulated by Rosenstoch's (1974) and Becker and Mauman's (1975). This model focuses on the relationship which exists between an individual's belief and behaviour.

4. **Agent- Host Environment Model:** The agent-host environment model describes the cause of illness in various other health areas and centres. It mentions that the level of health or illness of any person depends completely and entirely on the dynamic relationship of the agent, the factors which can lead to illness be it internal or external factors. Thereby when there is balance then it leads to health to be maintained up properly whereas if there occurs any sort of unbalance diseases might tend to occur. Agents can be biological physical, chemical, Psycho Social. Host factors are physical or psychosocial situations that puts individuals at risk. Lastly environment includes external factors.

Dimensions of Health

Look us look at the various dimensions of health which are largely categorized as physical, the mental and social. Others also exist which we will be highlighted ad discussed below.

1. **Physical Dimension:** The physical dimension of health means when the body functions are performed in a proper way. Various signs exist such as good complexion, clean skin, and bright eyes and so on which are said to be physical dimensions which states that the body is functioning properly and sounded.
2. **Mental Dimension:** Good mental health is also important which means a state of balance between a person and the surrounding world. Let us look at the few features which are important for an individual to be described as a mentally healthy person: well adjusted, free from any sort of conflicts, strong sense of self-esteem and so on.
3. **Social Dimension:** Integration and harmony with the person is very important as well as with the community and society and the whole world in which they live.
4. **Spiritual Dimension:** It means that part of a person's life which strives for meaning and purpose.
5. **Emotional Dimension:** it means feelings of an individual.

Other dimensions also exists such as that of philosophical dimension, cultural dimension, socio economic dimension, environmental dimension, and so on.

Determinants of Health

Let us look at few important determinants of health which are discussed below:

1. **Heredity/Human Biology:** Health is determined to a great extent by genetics. Similarly, gender of an individual also plays a very important factor here. For instance, if we look at women, one finds that, in last few decades it is reported that women are seen to record the higher rates of chronic and acute sickness and thereby tend to find and have a higher mortality rate as compared to men.

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2. **Environment:** Environment has a very important role to play on the well-being of humans. Environment can be both external as well as internal. The former contains those things and materials which human being is exposed after conception. Whereas the latter comprises in itself each and every part of the component, every organ every part, and so on.
3. **Lifestyle:** Lifestyle means the way people live. In today's time, one finds that lifestyle plays a very important role in the health of human beings. Poor sanitation, personal hygiene and cleanliness all tend to have a very important role in the overall health of humans.
4. **Resources:** the resources that help to maintain health of an individual are socio economic conditions, education, economic status, occupation of an individual, political system, etc.
5. Apart from all these various other factors such as language, diet, hygiene, habits such as smoking, consuming alcohol, and so on also have a role to play.

Mortality Indicators

1. **Crude Death Rate:** Crude death rate refers to number of deaths as per 1000 population per year in a particular given community. It shows the rate and pace at which people die.
2. **Life expectancy:** Life expectancy at birth means "the average number of years that will be lived by those who are born alive into a population if the current age-specific mortality rates exists. One finds that if there is an increase in the expectation of life of an individual then that is regarded as an improvement and wellbeing in the health status of the person concerned.
3. **Infant Mortality rate:** Infant Mortality rate refers to the ratio of deaths under the one year of age in a given year to the total number of live births in the same year.
4. **Child Mortality Rate:** Child Mortality Rate is defined as the number of deaths at the ages 1-4 years in a given year per 1000 children in that particular age group at the mid-point of the year.
5. **Maternal mortality rate:** this is seen to account for the greatest proportions of deaths among women of reproductive age in most of the developing world.

Morbidity Indicators: If we talk about morbidity indicators then one finds that during of stay in hospitals, attendance of OPD and various other reasons are used in order to know and assess the ill health of the community.

Disability Rates: disability rates are increasing day by day at a large scale. Disability rates are divided into the following two groups which we will be discussing now.

a) **Event type indicators:** This includes number of days of restricted activity, Bed disability days and Work-loss days

b) **Person type indicators:** This includes limitation of daily activity and limitation of mobility.

Nutritional status Indicator: Nutritional status Indicator is seen to be important indicator when talked in context of health.

Global health

Health differs all over the world. Let us look at detail as to how health differs all over the world.

1) **Heath in High income nations**: Obesity is found to be quite in large proportion and rising at a great pace in high-income nations. This has been linked and found in relation to many diseases such as cardiovascular problems, respiratory diseases, etc. The United States has the highest obesity rate for adults, whereas Canada secured fifth position in it.

   Wallace Huffman (2006) has suggested upon various indicators which have led to a rise in obesity in developed countries which are as mentioned below:

   1. Improvements in technology and reduced family size have resulted in the reduction of work to be done in households.
   2. Various unhealthy market goods now have replaced home goods.
   3. Leisure activities such as computer games and internet surfing are now taking place at a very great pace.
   4. There is a shift of workers to service industries.
   5. There is now use of more passive transportation eventually which leads to less walking of people to commute to places.

2) **Heath in Low income nations:** Low-income countries must manage various issues such as those of infectious diseases, high infant mortality rates, inadequate water supply, and hygiene conditions and so on. Low-income nations are generally found to have higher rates of infant mortality and lower average life spans due to multiple reasons few just mentioned above. Lack of access to clean water supply and basic sanitation is one of the major concern of them. According to a 2011 UNICEF report, almost half of the developing world's population lacks improved sanitation facilities which is a very serious concern which must be dealt immediately.

Attitude towards Health Behaviour

"Health behaviour" is defined as any sort of behaviour or habits of a person that is related to health care and health improvement. Many other theorists link it with the lifestyle of human beings to a great extent. Thereby it covers a broad range of actions and activities which are done by the individual concerned which include healthy nutrition standards, vaccination, and so on. Furthermore, there are many models which explain the health behaviour phenomenon. For instance, there is the health belief model whereby the health behaviour appears out of the perception of a disease threat and further having the aim of neutralizing this threat. Another theory which is the protection motivation theory is present where the health behaviour stimulus is the feeling of fear. This theory is based upon the assessment of threat and overcoming such a threat.

Theoretical Models of Health Behaviour

Social cognitive theory: This theory focuses on the people and their environment which are found to interact at a continuous speed. One finds humans to be influenced by the world round them they can also change the world in which they live.

Furthermore, Social cognitive theory provides the basis for a number of behaviour change strategies, for example the use of behavioural models who carry out a behaviour and gain positive outcome. Community organization describes the process by which community groups identify problems or objectives, gather resources, and develop ways to achieve upon their goals.

Behaviour change as a process: one needs to remember that Behaviour change is seen as a process and not an event. One needs to also keep in mind that in one day a person doesn't decide and quit smoking for instance. Similarly in a same manner it's difficult for people to change their eating habits in a single day. It is a continuous proves which takes time. Further there exists various multistage theories of behaviour change which date back to the early 1940s however it gained recognition in the end of twentieth century.

Changing behaviour versus maintaining behaviour changes: Undertaking a behaviour change and maintaining the change requires different types of programs and self-management strategies.

Health Inequalities

Health inequalities continue to remain a major concern globally. Health and illness are distributed in an increasingly unequal way all over the world. Often illness is seen in relation with poverty and deprivation. Furthermore, current societies are found to show features such as those of inequalities in the well-being of an individual , further stressing on the importance of decreasing socio-economic differences in health in future health and welfare policies. Moreover, over the world, many countries are facing large-scale social challenges due to the financial crisis which has taken place and has eventually resulted in poverty, high levels of unemployment,

as well as exclusion of people. This has resulted in the growing gaps generationally which would eventually make the future generations to suffer more and more.

Access to Healthcare

The term "access" is commonly used in two ways. Firstly, having access to anything means the potential and capability to utilize a service. Having access to any sort of service means in simple terms that the particular kind of service is available for use and further that there exist systems which would further allow for service to be utilized following contact with the health care service provider. Secondly, access means as actual procedure of admission into the process of utilizing the service.

There are aspects when it comes to access to healthcare. Let us look at them below.

1. **Availability:** it means the availability of resources for delivering an intervention. For instance, the number of health facilities or the technology available in relation to the target population is very important factor.
2. **Accessibility:** when any kind of service is available it is necessary for it to be located in a close proximity so that people are able to take advantage and use it in a good way. There occurs two main dimensions of accessibility: firstly physical access and secondly affordability. Time is also very important in this context. As such when an individual travels to any kind of health facility located in the area and the waiting time there is very well associated with the individual's perception of that particular access of the services.
3. **Acceptability:** when any health service or health service provider is found to be appealing and encouraged by people making them to visit that particular health service then it is said to be acceptable in people's eyes. Accessibility tends to include many non-financial factors such as religion, culture, beliefs, gender, etc.
4. **Contact:** this is seen as the actual contact which takes place between the service provider and the user.
5. **Effectiveness:** effective coverage is the proportion of the population in need of an intervention who have received an effective intervention.

Access and utilization as a continuum: any sort of contact and touch with the health care service provider form a continuum and access might be defined as some point on this continuum. Further, there exists many potential events and series in the process of contact and utilization of services which tend to indicate access.

- When a person happens to live to close proximity to any particular health care service provider.
- When a person is fully aware and conscious of his or her need for any particular services.

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- When the person is fully aware and conscious of his or her need for the services provided by the health care setting.
- When the person is in contact telephonically with the health care service provider.
- When the person is in contact via the internet with the health care service provider.
- The individual enters the health care setting.
- When there exists communication between individual and a health care worker.

Furthermore, equity is seen to be an important aspect when it comes to allocation of resources. In terms of health care, health care resources should always be distributed among people and groups according on the basis of need. Equity in terms of access to services has two aspects: first, Horizontal equity exists when groups with equal needs have equal access to health care and secondly, Vertical equity exists when groups with different needs have appropriately different access to health care. Furthermore, the health needs of different sort of groups may tend to vary. It differs in terms of quantity as well as it differs in terms of quantity. Further, in a given state of health, different groups and people may happen to rate their perceived health in a totally different manner. As such when faced with different health groups one finds that they tend to have different health needs. Thereby it is necessary that one identifies groups whose needs are not met up. Now when an individual happens to take into consideration the financing of health services, equity then means the level to which equitable consideration is made in relation to its ability to pay. Similarly, inequalities in health may occur in terms of socio economic status of an individual and one finds that further there exists many sorts of health measures to be associated with lower socioeconomic status. Tudor Hart has described this process. He says that there exists 'inverse care law' which means that there exists a situation whereby people in deprived areas are seem to have greater health needs but on an average level they are the ones who lack access to health care facility. This type of generalization has received a very well documented support all over the nation.

Furthermore, Goddard and Smith (1998) point out that health care needs and specialties of different people and groups are not homogenous. They reiterate the same by saying that it is the deprived and least marginalized section of group of people who happen to experience much more numerous and complex health problems than the ones who are found to be affluent. For instance, if we look at the prevalence of smoking one finds that it shows a strong inverse association with the socioeconomic status of an individual or group but smoking cessation needs to be much more intense in groups with lower socio-economic status due to the presence and prevalence of various other factors which are associated with the

same such as that to be which relates to education or income as such. Culyer and Wagstaff (1993) highlighted and said that equity in health care should entail distributing health care in such a way as to get as close and feasible to an equal distribution of health'. Thereby it is very much evident and clear access to health care are more limited in deprived social groups.

5.2.1 Current Trends in Terms of Healthcare

In the United Kingdom, the government responded in favour with the concern about access to health care with the NHS Plan. The NHS plan highlights on the policy framework which focuses on the development of services with the aim of resolving some of the problems of access in the NHS.

Service developments are found to aim at improving access to health care in two main areas: the interface between the individual, or community, and primary care services, and the interface between primary and secondary care services. Further one finds that those working with the NHS plan have argued on the fact that there occurred a wide gap between health needs and health services. They have said that this was due to the reason that there lied chronic underfunding with a less staff presence, lack of hospital beds, and so on. Further, it was argued that patients experienced too much waiting time in the hospital, and there was presence of too much variability across the country in levels and quality of service. The NHS plan now proposes upon in modernizing. This they argue can be done by changing the systems of service delivery in order to promote patient empowerment and education. Furthermore, the plan incorporates and gives a lot of suggestions and remedies. This will include facilities and pathology; multidisciplinary teams focused on particular groups and conditions; mix of nurse, therapist, consultant and GP-led services; fast access to acute settings when needed; access to non-acute inpatient settings where appropriate; timely discharge into appropriate settings.

Check Your Progress

1. How is medical sociology seen?
2. Who developed the high-level wellness model?
3. What is crude death rate?
4. List the two groups in which disability rate is divided.
5. List two events in the process of contact and utilization that tend to indicate access.
6. What do service developments aim at?

5.3 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

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1. Medical sociology is seen as the systematic study of how human beings manage issues of health and illness, disease and health care for both the sick as well as for the healthy ones.
2. The high-level wellness model was developed and formulated by Halpert Dunn (1977).
3. Crude death rate refers to number of deaths as per 1000 population per year in a particular given community. It shows the rate and pace at which people die.
4. Disability rates are divided into the following two groups:
   - **(a) Event type indicators:** This includes number of days of restricted activity, Bed disability days and Work-loss days
   - **(b) Person type indicators:** This includes limitation of daily activity and limitation of mobility.
5. The potential events and series in the process of contact and utilization of services which tend to indicate access are:
   - (i) When a person happens to live to close proximity to any particular health care service provider.
   - (ii) When a person is fully aware and conscious of his or her need for any particular services.
6. Service developments are found to aim at improving access to health care in two main areas: the interface between the individual, or community, and primary care services, and the interface between primary and secondary care services.

5.4 SUMMARY

- According to the national health policy (1982), appropriate communication strategies provide us with health information in an understandable form for forming up of an attitude necessary for a healthy living.
- Medical sociology is seen as the systematic study of how human beings manage issues of health and illness, disease and health care for both the sick as well as for the healthy ones.
- There are many actions of an individual which can be labelled as health behaviours that include smoking, diet, physical diet, sleeping, etc. Health behaviours of an individual concerned are discussed as individual-level behaviours.

- The Ecological Concept of health tends to view health as a dynamic equilibrium which takes place between man and his environment and it views diseases as a maladjustment of the human organisms. It further believes that in order to protect oneself from unhealthy factors we need clean air, water and so on.
- The high-level wellness model was developed and formulated by Halpert Dunn (1977). This model tends to look at maximizing the health potential of an individual, family or community.
- The agent-host environment model describes the cause of illness in various other health areas and centres. It mentions that the level of health or illness of any person depends completely and entirely on the dynamic relationship of the agent, the factors which can lead to illness be it internal or external factors.
- The physical dimension of health means when the body functions are performed in a proper way. Various signs exist such as good complexion, clean skin, and bright eyes and so on which are said to be physical dimensions which states that the body is functioning properly and sounded.
- Lifestyle means the way people live. In today's time, one finds that lifestyle plays a very important role in the health of human beings. Poor sanitation, personal hygiene and cleanliness all tend to have a very important role in the overall health of humans.
- Life expectancy at birth means "the average number of years that will be lived by those who are born alive into a population if the current age-specific mortality rates exists. One finds that if there is an increase in the expectation of life of an individual then that is regarded as an improvement and wellbeing in the health status of the person concerned.
- Low-income countries must manage various issues such as those of infectious diseases, high infant mortality rates, inadequate water supply, and hygiene conditions and so on. Low-income nations are generally found to have higher rates of infant mortality and lower average life spans due to multiple reasons.
- "Health behaviour" is defined as any sort of behaviour or habits of a person that is related to health care and health improvement. Many other theorists link it with the lifestyle of human beings to a great extent. Thereby it covers a broad range of actions and activities which are done by the individual concerned which include healthy nutrition standards, vaccination, and so on.
- Social Cognitive Theory focuses on the people and their environment which are found to interact at a continuous speed. One finds humans to be influenced by the world round them they can also change the world in which they live.
- Current societies are found to show features such as those of inequalities in the well-being of an individual , further stressing on the importance of

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decreasing socio-economic differences in health in future health and welfare policies.

- Having access to any sort of service means in simple terms that the particular kind of service is available for use and further that there exist systems which would further allow for service to be utilized following contact with the health care service provider.
- Equity in terms of access to services has two aspects: first, Horizontal equity exists when groups with equal needs have equal access to health care and secondly, Vertical equity exists when groups with different needs have appropriately different access to health care.
- Goddard and Smith (1998) point out that health care needs and specialties of different people and groups are not homogenous. They reiterate the same by saying that it is the deprived and least marginalized section of group of people who happen to experience much more numerous and complex health problems than the ones who are found to be affluent.

5.5 KEY WORDS

- **Health Behaviour:** It is defined as the activity undertaken by people for the purpose of maintaining or enhancing their health, preventing health problems, or achieving a positive body image.
- **Infant Mortality Rate:** It refers to the ratio of deaths under the one year of age in a given year to the total number of live births in the same year.
- **Heredity:** It is the passing on of physical or mental characteristics genetically from one generation to another.
- **Crude Death Rate:** It refers to number of deaths as per 1000 population per year in a particular given community. It shows the rate and pace at which people die.
- **Social Cognitive Theory:** It is a theory that holds the opinion that portions of an individual's knowledge acquisition can be directly related to observing others within the context of social interactions, experiences, and outside media influences.

5.6 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. How has Perkin defined health?
2. What does the idea of the social construction of health emphasize?

3. Write a short note on Health-Illness Continuum model.
4. List two dimensions of health.
5. Define Child Mortality Rate.
6. What are the two ways in which the term 'access' is used?
7. What are the two aspects of equity in terms of access to services?

Long-Answer Questions

1. Discuss the four concepts of health.
2. Elaborate upon the determinants of health.
3. Analyze the aspects of access to healthcare.

5.7 FURTHER READINGS

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UNIT 6 SOCIAL MEDICINE AND COMMUNITY HEALTH

Structure

6.0 INTRODUCTION

Social medicine is a field that is concerned with an investigation of several factors that influence diseases among humans. These factors are genetic, environmental and social. In addition, it aims to prevent the spread of such diseases and promotes an understanding of conditions that lead to such diseases. Community health is a related concept that studies how people are determinants of their own health as well as that of others around them. Both of these concepts are aimed at gaining an understanding of the factors responsible for the spread of diseases and their prevention. In this unit, these concepts have been discussed along with the functions of major voluntary health agencies in India.

6.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the concept of community health and the factors influencing it
- Analyze the concept and variations of social medicine
- Examine the functions of the major voluntary health agencies in India such as Voluntary Health Association of India (VHAI), Indian Red Cross Society (IRCS), Indian Leprosy Association and many others

6.2 COMMUNITY HEALTH

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Traditionally, a community has been thought of being confined to a geographic area with specific boundaries, for example, a neighbourhood, city, country, or state. However, in the context of community health, a community is an aggregate of people who share certain common characteristics. Community is also related with a particular geographical location, race, ethnicity, age, and occupation who are having common interests for particular problems and having a common bonding (Turnock, 2004).

Communities are characterized by following features:

- Membership: community people have a sense of common identity and belongingness.
- They share a common language, rituals, and ceremonies.
- Their values and norms are common.
- Members have a mutual influence and also influenced by each other.
- Their needs are shared and committed to meet their common needs.
- They are also connected by emotions in terms of their common history, experiences and mutual support (Israel et al., 1994).

Examples of communities include the people of a city (location); a community, say the Dravidian community of South India (race), the tribal community example Odisha (ethnicity), seniors (age), doctors and teachers (occupation), or local union members (common bond). A community may be small— as the group of people who live in accommodation provided in the hostels at college or university or as large as the individuals who make up a nation. "A healthy community is a place where people provide leadership in assessing their own resources and needs, where public health and social infrastructure and policies support health, and where essential public health services, including quality healthcare, are available" (Institute of Medicine, 2003).

Defining Community Health

Prior to defining community health, a similar concept, i.e. public health is discussed. The laymen use these two terms interchangeably in various health fields. Most people are referring to the collective health of those in society and the actions or activities taken to obtain and maintain that health. Public health is an inclusive concept. When the activity is done publicly to assure the conditions in which people can be healthy is called public health. The public health system, which has been defined as certain actions and activities taken in formal structure by the government, private, voluntary organizations, and by individuals (Institute of Medicine, 1998), is the organizational mechanism of providing such conditions. People regard public

health as the responsibility of government like providing sanitation, potable water, vaccination, control and prevention of epidemics, etc.

Community health refers to the health status of a defined group of people and the actions and conditions to promote, protect, and preserve their health (Mckenzie et al., 2008).

Personal health activities are individual actions and decision making that affect the health of an individual or his or her immediate family members. These activities may be preventive or curative in nature but seldom directly affect the behaviour of others. Choosing to eat nutritious food, regular exercise, avoiding smoking, etc., are examples of personal health activities.

Community health is concerned with the health problems among different groups of population. Such concerns with health problems of population groups inevitably lead to a broad range of interests, i.e. from the cause, prevention, and control of diseases—nutritional or otherwise. Thus community health includes identification of nutritional and health problems and causes, prevention, and control of diseases.

However, the community health has replaced, in some countries, the terms of public health, preventive medicine and social medicine. A EURO symposium in 1966 defined community health as including "all the personal health and environmental services in any human community, irrespective of whether such services were public or private ones". In some instances, community health is used as a synonym for 'environmental health'. It is also used to refer to 'community healthcare'. Therefore, a WHO expert committee in 1973 observed that without further qualification, the term 'community health' is ambiguous, and suggested caution while using the term.

Community health is defined more broadly and encompasses the entire gamut of community-organized efforts for maintaining, protecting, and improving the health of the people. It involves motivation of the individual and groups to change their patterns of behaviour. In addition, it also seeks to plan medical care to achieve optimal health of the members of the whole community. Previously, the subject of community health was covered under Hygiene, Public Health or Preventive and Social Medicine.

In community health, instead of studying individuals as a patient, it is essential to understand that:

- The patient represents the community
- Diagnosis of disease in the community, (referred to as community diagnosis) is essential
- Planning treatment for the community is the objective.

For example, a single case of a cholera patient detected in a village is a danger signal. It shows that the disease is present in the community, there may be

many cases of it and unless checked, its spread will grip the whole village. So the appropriate measures for treatment and control of the disease are planned in advance. Since it is a water-borne disease, water sources—river, wells, or underground water are examined for infection and accordingly treated. In addition, necessary treatment for the affected people and precautions such as vaccination for vulnerable people is also done. Community diagnosis may require relevant data such as given below. These are collected and interpreted.

- Age and sex distribution in the population under study and its distribution in social groups—in the community.
- Crude birth rate, infant mortality rate, maternal mortality rate, child death rate, prenatal mortality rate and neonatal post- neonatal death rate, etc.
- Incidence and prevalence of certain diseases in the area.

Besides investigating health problems, it is also essential to find out the various social and economic factors in the area influencing the above data. This helps in identifying the basic health needs and health problems faced by the community. After studying all the problems, the priorities are established and community action is planned. This involves a health service system which plans for improvement of water supplies, immunization, health education, control of specific diseases and it requires health legislations. Such health services are planned at individual level, family level, and at the level of community. It is also essential that healthcare is planned in such a way that it could be easily utilized by all and encourages people to participate. Another positive feature of community action is that it brings coordination between voluntary organizations and government agencies engaged in overcoming similar problems.

Factors Influencing Community Health

Community health activities are activities that are aimed at protecting or improving the health of a population or community. These include activities such as maintenance of accurate birth and death records, protection of food and water supply, and participating in a vaccination drive. Community health depends on the interplay of a number of complex factors which exert their influence on the lifestyle of the individual. Some of them are beyond the control of the individual, while others are more amenable to personal manipulation. Four major interrelated determinants can be identified. They are:

- Genetics
- Social and cultural factors
- Physical factors such as personal health behaviour
- Health services

These determinants are discussed separately.

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Genetics

Genetics is a very important determinant of health and it operates in several ways. Certain individuals are born with specific genetic abnormalities, which give rise to particular nutritional problems. It is well known that diabetes shows a familial tendency. Certainly, the children of two diabetic parents have about one in four chances of developing the disease at some stage of their lives. If only one parent is affected, the chances are reduced to about one in eight. You must have observed that obesity in children is also more common when the parents themselves are over-weight. In this case, environment also has an influence. Environment, lifestyle and nature of occupation may be responsible to predispose the condition of obesity. Heart disease also exhibits familial tendencies. It would be reasonable to suppose that there is an inborn susceptibility to specific diseases and that the manifestation and seriousness of these is a consequence of life experiences. The more negative factors present in the environment or personal behaviour patterns, the more likely the disease will occur.

Social and Cultural Factors

Social factors are those that arise from the interaction of individuals or groups within the community. For example, those who live in the metropolitan cities, where life is too fast, experience higher rates of stress-related illnesses than who live in rural societies, where life is simple. Rural areas may not have the same quality of healthcare facilities which are available to the urban people. Besides factors, those cultural factors also influence community health. Culture includes the beliefs, traditions, and values. There are certain types of health beliefs which are present among the communities and they exercise them. The traditions of specific communities for seeking a particular type of treatment for particular type of health problem depict their health behaviour.

Economy of any country or in particular, the economy of the community also influences the health of its people and healthcare facilities. The growth of economy puts its resources towards the health budget and, in turn, it enhances the health of its people.

The National Health Policy by the government is an important political decision which is directly related to the health of the nation. More coverage of people for providing state health facilities is a government decision and in turn, it affects the health of the population.

A number of religions have taken a position on healthcare and health behaviours. For example, some religious communities limit the type of medical treatment their members may receive. Some religious communities do not permit immunization, contraception for family planning, and certain taboos for certain foods. Some religious communities actively address moral and ethical issues such as abortion, premarital intercourse, and homosexuality. Still other religious teach

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health-promoting codes of living to their members. Obviously, religion can affect a community's health positively or negatively.

The influence of social norms can be positive or negative and can change over time. For example, earlier smoking was accepted in the normal routine, however, by making it an offence in the public place, people have started looking down on a smoker. Thus, the numbers of smokers in the public places has gone down.

Physical Factors

Physical factors are important in terms their effect on health. They include the influence of geography, the environment, community size, etc. A community's health problems can be directly related to its altitude, latitude, and climate. In a tropical country like, India where there is warm and humid temperature, parasitic diseases and infectious diseases are a leading community health problem. Survival from these diseases is made more difficult because poor soil conditions results in inadequate food production and malnutrition.

Environmental improvements such as better sanitation and education, availability of good food, lead to better health and a large proportion of the decline in mortality and morbidity of the country may be attributed to this. In some instances, environmental influences have been directly or indirectly detrimental to nutritional status. In case of nutrition, the environment provides a framework within which individual choice can operate.

The larger the community, the greater is the range of health problems. Larger population also poses a problem of scarce community resources, and which lead to the scarcity of food and healthcare facilities. The ability of a community to effectively plan, organize, and utilize its resources can determine whether its size can be used to good advantage.

Personal Health Behaviour

Personal health behaviour denotes the individuals' choice related to health issues. Personal health behaviour is the ultimate decider of the food choices. Individuals will choose whether to smoke or drink, whether to take exercise or be immunized and so on.

The anti-health effects of personal behaviour can be seen to be manifested as:

- Adoption of undesirable health habits
- Rejection of healthcare and non-compliance
- Indirectly a creation of high risk environment

Inappropriate behaviour can lead to health problems. Hence, health education is directed as persuading people to act in their own best interests.

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Socio-economic status is an important consideration in health, whether, a cause or consequence, it is linked with other major detriments. Poor mental capability may lead to reduced progress in education and subsequently restricts job opportunities. Lower income, in turn, will restrict food choice. Lack of education may affect personal decision making skills and contribute to underuse of services and bind more to traditions and beliefs. In order to control this, what is to be done? Should one make an attempt to control environment and services or should one concentrate on influencing personal behaviour?

Health Services

Provision of health services will affect health status. For example, if no nutrition and health education is available, then people are not able to seek help for nutritional problems. It is likely that nutritional problems like vitamin A deficiency and non-deficiency continue to exist and the nutritional status of the community will be deteriorated. The nature of services whether preventive or curative is also important, otherwise mortality and morbidity rates among vulnerable segments of the community will be on the increase plane. One of the problems of services is that they are often underutilized by the people who would benefit from them most. Basing services in the community rather than in the hospital may help to make them more accessible and, therefore, increased utilization.

Check Your Progress

1. Give some examples of communities.
2. What are personal health activities?
3. What are the four major interrelated determinants of community health?
4. What are social factors? Give example.

6.3 SOCIAL MEDICINE

Community medicine is the successor of what has been previously known as public health, preventive medicine, social medicine, and community health. Since community medicine is a recent introduction, it has borrowed heavily from the concepts, approaches, and methods of public health, preventive medicine, and social medicine.

The term community medicine means different things in different countries. For example, in most European countries, various aspects of community medicine are taught in medical universities though under different names, such as general practice, family medicine, community medicine or social medicine.

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These variations are reflected below:

- The area of the study of health and disease in a population of a particular group or community. The goal of the study is to identify the health problems and needs of particular group or community and then to plan, implement, manage, and finally to evaluate the extent to which health measure can be effectively implemented to meet these needs.
- The practice of community medicine is related with the community or group and not with the individual.
- Community medicine concept is also used to describe the practice of medicine in the community or group, for example by a family physician. The other equivalent term with family medicine are community medicine.
- In the community. primary health the integration of medicine with the primary healthcare of the individual is included. Here the community practitioner or community health team are responsible for healthcare of the community and also of the individual.

It can be summarized that community medicine is a practice which focuses on the health needs of the whole community. "The combination of community medicine with 'primary health care' extends the functioning of both elements to healthcare systems which aims to change the state of health of the community by intervention both at the individual and group level."

6.3.1 Global Health

Global health is inter-related with public health and international health. Hence, the concept of global health often overlaps with that of public health and international health. The concern of global health has originated from epidemics, hygiene, and tropical medicine. But how does one define global health?

Kaplan (2009) has tried to define global health as a notion in which the world is viewed as an aggregate of healthy people who are engaged in research and practice related with certain issues of health. Although, there is a need for commonly accepted definition of global health, it should be extended beyond semantics. Global health might have some differences at the level of philosophy, strategies, and priorities for action between physicians, researchers, funders, media and the general public. The definition of public health is suggested by Winslow (1920), and it seems that it is closer to the concept of global health. Winslow defines public health as the science and art of preventing diseases, extending life and quality of physical life though organized community efforts. The community efforts are directed towards sanitation and environment for controlling communicable infections and educating the individual on personal hygiene. The organizations of medical and nursing teams are needed for early detection and diagnosis and preventive treatment of disease and the social mechanisms so that every individual is assured of living adequate for the maintenance of health. This will ultimately enhance the longevity and translate into his/her birthright.

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The US Institute of Medicine, in 1988, in their report on Future Health, described public health in terms of its mission, substance, and organizational framework which will translate in tackling the preventive aspect. Community approach is given emphasis over the individual approach. In the dictionary, public health is defined as the efforts to protect, promote, and restore people's health. Public health is the aggregate of sciences, skills, and beliefs that are directed to the maintenance and improvement of the health of all through collective actions and efforts. In the beginning, it has been mentioned that global health is an overlapping area of public health and international health. These overlapping areas are mentioned below:

- priority on preventive measures
- more focus on poor, vulnerable, and under-served population
- multifactorial and interdisciplinary approaches
- priority on health as public good and the importance of systems and structures
- participation of stakeholders

Public health and international health show commonalities and thus, focus on global health. Thus, global health is affected by transnational determinants like environmental changes, urbanization, epidemics, and other health issues. Specifically, epidemic issues like AIDS, infectious diseases (dengue, influenza) are global diseases. But before diseases, the global concern is to address the tobacco control, micronutrient deficiencies, obesity, injury prevention, migrant workers' health etc. (Kaplan, 2009).

Thus, global health refers to the domestic disparities as well as cross-border issues. Global health also focuses on funding to the under-developed nations so that they are treated well. It also incorporates the training and distribution of healthcare manpower in the under-developed society. The analysis of global health also raises the pertinent question that it is directed towards infectious diseases, maternal and child health issues. Global health should also address the issues of chronic diseases, injuries, mental health and environment. However, in the actual situation, infectious diseases, maternal and child health are the major areas which seek the attention of global health, but it should also direct its efforts to under-nutrition and over-nutrition, tobacco related diseases, mental health, etc. Dietary changes are rapidly taking place and in turn it is giving birth to lifestyle diseases which are also the concern of global health. Lack of physical activity, increased dependency on automobiles, smoking, drug abuse, stress, etc., are threats to health, and therefore priorities should be set. Global health also focuses on the researches done across the cultures and find out the better prevention module for certain culturally specific diseases. Thus, global health uses the resources, knowledge, and experiences of diverse cultures in addressing the global health challenges throughout the world. Global health in the true sense is an interdisciplinary approach for prevention, treatment, and care of the society as a whole.

6.4 HEALTH CARE AND AGENCIES

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Voluntary organizations are the non-official, traditional organizations that are set-up by groups of civic-minded and philanthropic people to serve the social and health needs of the community. These organizations exist for humanitarian and selfless motives, with focus on 'service to the community', and contribute significantly to the public healthcare system of the nation. Voluntary healthcare organizations are either endorsed by the contributions made voluntarily by the people or by the paid services, and are liable to the contributors of the organizations, to the third party payment sources, and are free to support and experiment, like Voluntary Health Association of India.

Functions of Voluntary Organizations

Voluntary organizations have a long term history of contributing in the promotion of human well-being and welfare. These are the private undertakings for the progress of society. Voluntary action is the soul and essence of the democracy as it acts as a medium to ensure that people are actively involved from policy-making to the enforcement of the social services. The programs run by the voluntary organizations cover a wide variety of functions dealing with health and welfare of human beings. These programs include specialized, highly professional, and technical people assembled for a specific objective. Several national level organizations are linked with the associations or federations at the international level. There are various organizations, which have an indirect influence on the promotion of healthcare programs instead of direct involvement. The programs of direct relevance to healthcare administration and management include the projects for the improvement of food production, nutrition and housing, promotion of literacy rate, provision of potable and safe water, availability of instructional and educational material, community development, women and child welfare, improving environmental sanitation, etc. Therefore, they help to prevent illnesses and promote health. Some of the major functions of Voluntary Health Agencies (VHAs) in India are:

- Providing direct services or assisting individuals involved in the activities like programs for patient care, providing nursing services, consultations or other professional healthcare services to the people
- Supporting directly or through funds and grants the research in the areas of medical and health sciences as well as in the processes of financing and distributing healthcare services. That is why, VHAs can better explore means and ways of organizing new activities
- Assigning the jobs of supervision and training of the volunteer workforce either to other organizations or directly providing supplementary services
- Supplementing the work of official agencies by preparing and disseminating information material to general public. The official agencies are unable to

provide complete services because of certain statutory or financial limitations and restrictions. The VHAs can contribute by raising funds for important equipment or providing other supplementary support services to the agencies

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- Assisting in recruiting and training of personnel by arranging scholarships and grants for different demonstration services to continue the program
- Under other sources, guide the work of official agencies by criticising and evaluating the official agencies

Voluntary Health Agencies in India

There are several voluntary health agencies working in India since the pre-independence period. Initially, the health services started in India with some voluntary groups, for instance, the missionaries from other countries provided services for children, women, and patients suffering from leprosy, some of which are still playing a major role in the health care programmes in the country.

(I) Voluntary Health Association of India (VHAI)

VHAI was established in 1970 as a registered, non-profit society. It is an association of twenty seven States' Voluntary Health Associations and links more than 4500 institutions, which are contributing to health development in the country. They advocate the policies, which are public-centric for dynamic program management and health planning in India. They have supported and initiated innovative and novel programs focusing on the health and development at the grass root level with the active involvement of people. They strive to bring a strong and sturdy healthcare movement in India for a developing, cost-effective, preventive, and reformative health system. VHAIs are accountable for a responsible private and public health sector and quality service. They promote various health issues related to rights and comprehensive development of people. Following are its goals and objectives:

- To make health development a reality for the people of India
- To promote and strengthen a medically rational, economically sustainable, and culturally acceptable health care system in the country
- To ensure equity, social justice, and human rights in the provision and distribution of health care services to all, with focus on the less privileged population
- To develop innovative and sustainable strategies to ensure health and overall community development in the remote and vulnerable areas, through various grass-root level initiatives

(II) Indian Red Cross Society (IRCS)

IRCS was formed in 1920 and operates with the help of organizations at national and international levels. Presently, it has above four hundred functioning branches in India. It provides training to the community members in various medical

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procedures and also focuses on some health issues. Following are its major functions:

- Providing relief operations during disasters like wars, earthquakes, floods or famine. For example, collecting and distributing clothes and food to the affected people.
- Supplying medicines, vitamin supplements, milk, etc. to the hospitals and dispensaries. It also provides services related to family planning.
- Assisting in relevant research related activities and offering scholarships to nurses for their upgrade.
- Offering first aid emergency training with the help of its branch i.e. 'St John Ambulance Association for men and home nursing courses for women'.
- Providing blood bank facility to the people.
- Publishing and distributing informative material related to mother and child care.

Indian Red Cross Society has 35 state association regions divisions, along with their 700 locale and sub-area divisions. The overseeing body is accountable for the administration and management of the elements of the general public via various number of advisory groups.

Impartiality, neutrality, humanity, independence, unity, voluntary benefits and universality are the fundamental principles of Red Cross Society.

(III) Indian Leprosy Association (Hind Kusht Nivaran Sangh)

Indian Leprosy Association is a prestigious agency devoted to the cure and rehabilitation of patients suffering from leprosy. Leprosy (Hansen's disease) is a chronic infection, which is caused by the bacteria Mycobacterium leprae and Mycobacterium lepromatosis. There are approximately 40, 00, 000 diseased patients in India. The phobia regarding the disease was particularly remarkable and therefore, the mass scale treatment and restoration program moved the diseased individuals, with the formation of Hind Kusht Nivaran Sangh, on an all India level in 1949. Hon'ble Leader of India is the Leader of the Association and affiliation health minister is the Chairman.

It provides financial assistance to various leprosy clinics and homes, and conducts research and field investigation and training of medical workers. The association has many branches in the country, which operate in collaboration with the government and several other voluntary organizations. It arranges 'All India Leprosy Workers' conferences and also publishes a quarterly journal *Leprosy in India*. It renders healthcare education through informative posters and publications. Following are the present activities of Sangh:

- Producing and distributing the material for health education and awareness about leprosy

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- Publishing the *Indian Journal of Leprosy* quarterly and a news bulletin 'Kusht Vinashak' bi-annually for the leprosy workers as well as general population
- Producing and distributing the 'leprosy seals' to make the people aware about leprosy and assist other agencies to raise funds for their activities by selling these seals
- Observing 30th January as Anti-Leprosy Day every year to spread general awareness regarding leprosy
- Conducting training courses for the duration of nine months at two training centres for leprosy in the country, one in Naini, Uttar Pradesh and other in Purulia, West Bengal
- To organize 'All India Leprosy Worker's and Regional Leprosy Worker's Conferences' in association with the other branches in the state and voluntary agencies
- To support leprosy patients and other voluntary associations
- To maintain a house known as 'Shanthi Illam' at Vellore in Tamil Nadu, where free boarding and lodging facilities are provided to the leprosy patients coming for surgical treatment at CMC College and Hospital.
- To run two mobile leprosy treatment units funded by the government of India in two districts of Delhi.

(IV) Indian Council for Child Welfare (ICCW)

Indian Council for Child Welfare (ICCW) was established in 1952 and is affiliated to 'International Union for Child Welfare'. Its activities are focused on securing those facilities and opportunities that will help in the physical, moral, psychological, social, and spiritual development of the children in a normal and healthy manner, with freedom and dignity. Ever since its establishment, it has created a networking matrix of the district and state councils across the country. It is an association working on the following:

- To advocate children's rights
- Crèches for children of working and ailing mothers
- To organize training programs for child care workers
- Sponsoring under-privileged children for school education
- To scrutinize adoption cases
- To rehabilitate abandoned children
- To provide institutional and day care services for differently-abled children
- To run programs for children living in difficult circumstances
- To run programs with a special emphasis on girl child

- To run support services and education centres
- To honour child artists
- To honour children for bravery
- To organize adventure/National Integration camps

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(V) Central Social Welfare Board (CSWB)

Central Social Welfare Board (CSWB) is a semi-official organization that was instituted in 1953 by the Government of India. Its establishment was the first attempt by the government to start a non-government organization that would operate voluntarily. Its main aim was to operate as a connection between the people and the government. Its major functions are:

- To survey the requirements of voluntary welfare agencies in India
- To synchronize and systematize welfare activities of the different departments of the state governments
- To provide financial assistance to the voluntary social organizations to extend their welfare services throughout the country, especially in remote and underprivileged areas.

In 1963, CSWB assumed the status of an autonomous organization and started 'Family and Child Welfare Services' in the rural regions for children and women. Important services under the project include upskilling the women through crafts, *balwadis*, distributing milk, and developing play areas for children. In the urban region, a scheme was initiated by the board to teach activities like sewing, tailoring, etc. to the lower middle class women with the cooperation of the industries, so that they can work and assist their families. In 1954, 'The State Social Welfare Boards were formed in all of the states as well as in the union territories with an objective to coordinate and systematize the developmental and welfare services managed by the several state government departments to assist voluntary organizations to expand their welfare activities all over the country. The main schemes initiated by the board included the provision of compendious services to the community in a united way. Some schemes and projects undertaken by the board include 'Mahila Mandals, Dairy Scheme, Welfare Extension Projects, Grant in Aid, Socio Economic Programme, Awareness Generation Programme, Condensed Education Programme for adolescent girls and women, Short Stay Home Programme, National Creche Scheme, Integrated Scheme for Women's Empowerment for North Eastern States, Vocational Training Programme, Innovative Projects and Family Counselling Centre Programme.'

In 1983, 'Family Counselling Centre (FCC)' scheme was initiated by the board to help the children and women, who are the victims of family maladjustments, atrocities, and social expulsion by providing counselling and rehabilitative services. In the cases of manmade or natural catastrophes, it imparts counselling services for crisis and trauma management. It works in collaboration with police, legal

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cells, courts, local administration, vocational training centres, healthcare and psychiatric organisations, etc. on the principle of 'People's Participation'.

Since its inception, it has made outstanding contributions for the weaker and underprivileged people through its welfare and developmental programs. It has also done significant work to empower children and women. The board is continuously analyzing and exploring contemporary and innovative channels to meet the changing social pattern to formulate the suitable action plans.

(VI) The Kasturba Memorial Fund

It was established in 1944 after the death of Smt. Kasturba Gandhi in her reminiscence. It raises the funds to help and serve rural masses through *gram sevikas*, mainly in the field of health and welfare of rural women and children working in a variety of difficult terrains all over the country from dense forests of North-east states to snow clad Himachal Pradesh.

(VII) Family Planning Association of India (FPAI)

Instituted in 1949, FPAI is headquartered in Mumbai. It has done a tremendous work to promote family planning programs in the country by working in collaboration with the government. It has now various branches throughout the country, which disseminate information on family life and sex, along with a broad range of services in 'Sexual and Reproductive Health Rights' for bringing health and happiness. It works on the following:

- Education of school, college students, and youth workers
- Helps the couples to plan spacing and number of children
- Organises conferences, seminars, and workshop
- Set up family life and marriage counselling
- Address reproductive and sexual concerns
- Focuses on sex instruction, advising, inquiring, preparing/treatment (SECRT)
- Specialised services on family life, marriage and sex counselling.
- Prevention and counselling of STI/STD/AIDS
- Training courses and workshop on human sexuality

(VIII) All India Women's Conference (AIWC)

Founded in 1927, AIWC is the oldest national women's organization in India. It focuses on education, liberation and empowerment of women. Its major functions include developmental and welfare activities for children and women and to spread awareness about the fundamental rights of the women. Their objective is to create a society for women, where they don't have to suffer from any type of violence. They run computer centres, training programs, hostels for working women, vocational training centres, etc.

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It has conducted activities in the field of health, education, and self-employment and also undertaken employment orientated training programs. With its dedication towards the upliftment and betterment of women and children, it has started a literacy campaign through non-formal education for girls, who have dropped out of school and a vocational training program for adult women through its 530 branches all over India.

(IX) All India Blind Relief Society

Instituted in the year 1946, All India Blind Relief society coordinates activities of various organisations working for the visually challenged people. Society organizes eye check-up, relief camps, and other interventions for the relief of the blind.

Check Your Progress

5. What has the concern of global health originated from?
6. What do the programs of direct relevance to healthcare administration and management include?
7. List two major functions of IRCS.
8. With what objective were the State Social Welfare Boards formed in all the states?
9. What are the major functions of All India Women's Conference (AIWC)?

6.5 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. Examples of communities include the people of a city (location); a community, say the Dravidian community of South India (race), the tribal community example Odisha (ethnicity), seniors (age), doctors and teachers (occupation), or local union members (common bond).
2. Personal health activities are individual actions and decision making that affect the health of an individual or his or her immediate family members. These activities may be preventive or curative in nature but seldom directly affect the behaviour of others. Choosing to eat nutritious food, regular exercise, avoiding smoking, etc., are examples of personal health activities.
3. The four major interrelated determinants of community health are:
   a. Genetics
   b. Social and cultural factors
   c. Physical factors such as personal health behaviour
   d. Health services

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4. Social factors are those that arise from the interaction of individuals or groups within the community. For example, those who live in the metropolitan cities, where life is too fast, experience higher rates of stress-related illnesses than who live in rural societies, where life is simple.
5. The concern of global health has originated from epidemics, hygiene, and tropical medicine.
6. The programs of direct relevance to healthcare administration and management include the projects for the improvement of food production, nutrition and housing, promotion of literacy rate, provision of potable and safe water, availability of instructional and educational material, community development, women and child welfare, improving environmental sanitation, etc.
7. Two major functions of Indian Red Cross Society (IRCS) are:
   - Offering first aid emergency training with the help of its branch i.e. 'St John Ambulance Association for men and home nursing courses for women'.
   - Providing blood bank facility to the people.
8. The State Social Welfare Boards were formed in all of the states as well as in the union territories with an objective to coordinate and systematize the developmental and welfare services managed by the several state government departments to assist voluntary organizations to expand their welfare activities all over the country.
9. The major functions of AIWC include developmental and welfare activities for children and women and to spread awareness about the fundamental rights of the women.

6.6 SUMMARY

- In the context of community health, a community is an aggregate of people who share certain common characteristics. Community is also related with a particular geographical location, race, ethnicity, age, and occupation who are having common interests for particular problems and having a common bonding.
- Personal health activities are individual actions and decision making that affect the health of an individual or his or her immediate family members. These activities may be preventive or curative in nature but seldom directly affect the behaviour of others.
- Community health involves motivation of the individual and groups to change their patterns of behaviour. In addition, it also seeks to plan medical care to achieve optimal health of the members of the whole community. Previously,

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the subject of community health was covered under Hygiene, Public Health or Preventive and Social Medicine.

- Community health activities are activities that are aimed at protecting or improving the health of a population or community. These include activities such as maintenance of accurate birth and death records, protection of food and water supply, and participating in a vaccination drive.
- A community's health problems can be directly related to its altitude, latitude, and climate. In a tropical country like, India where there is warm and humid temperature, parasitic diseases and infectious diseases are a leading community health problem.
- Personal health behaviour denotes the individuals' choice related to health issues. Personal health behaviour is the ultimate decider of the food choices.
- One of the problems of services is that they are often underutilized by the people who would benefit from them most. Basing services in the community rather than in the hospital may help to make them more accessible and, therefore, increased utilization.
- The term community medicine means different things in different countries. For example, in most European countries, various aspects of community medicine are taught in medical universities though under different names, such as general practice, family medicine, community medicine or social medicine.
- The US Institute of Medicine, in 1988, in their report on Future Health, described public health in terms of its mission, substance, and organizational framework which will translate in tackling the preventive aspect. Community approach is given emphasis over the individual approach.
- Global health also focuses on funding to the under-developed nations so that they are treated well. It also incorporates the training and distribution of healthcare manpower in the under-developed society.
- Voluntary healthcare organizations are either endorsed by the contributions made voluntarily by the people or by the paid services, and are liable to the contributors of the organizations, to the third party payment sources, and are free to support and experiment, like Voluntary Health Association of India.
- VHAI was established in 1970 as a registered, non-profit society. It is an association of twenty seven States' Voluntary Health Associations and links more than 4500 institutions, which are contributing to health development in the country.
- IRCS was formed in 1920 and operates with the help of organizations at national and international levels. Presently, it has above four hundred functioning branches in India. It provides training to the community members in various medical procedures and also focuses on some health issues.

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- Indian Leprosy Association is a prestigious agency devoted to the cure and rehabilitation of patients suffering from leprosy.
- Indian Council for Child Welfare (ICCW) was established in 1952 and is affiliated to 'International Union for Child Welfare'. Its activities are focused on securing those facilities and opportunities that will help in the physical, moral, psychological, social, and spiritual development of the children in a normal and healthy manner, with freedom and dignity.
- Central Social Welfare Board (CSWB) is a semi-official organization that was instituted in 1953 by the Government of India. Its establishment was the first attempt by the government to start a non-government organization that would operate voluntarily.
- Instituted in 1949, FPAI is headquartered in Mumbai. It has done a tremendous work to promote family planning programs in the country by working in collaboration with the government.
- Founded in 1927, AIWC is the oldest national women's organization in India. It focuses on education, liberation and empowerment of women. Its major functions include developmental and welfare activities for children and women and to spread awareness about the fundamental rights of the women.

6.7 KEY WORDS

- **Public Health:** It refers to the health of the population as a whole, especially as the subject of government regulation and support.
- **Community Health:** It is a branch of public health which focuses on people and their role as determinants of their own and other people's health in contrast to environmental health, which focuses on the physical environment and its impact on people's health.
- **Immunization:** It is the process of giving a vaccine to a person to protect them against disease.
- **Chronic Infection:** It is a type of persistent infection that is eventually cleared, while latent or slow infections last the life of the host.
- **Voluntary Organizations:** These are the non-official, traditional organizations that are set-up by groups of civic-minded and philanthropic people to serve the social and health needs of the community.
- **Upskilling:** It is the process of teaching employees new skills that will aid them in their work.

6.8 SELF ASSESSMENT QUESTIONS AND EXERCISES

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Short-Answer Questions

1. List the features by which communities are characterized.
2. Which activities do community health activities include?
3. How are anti-health effects of personal behaviour manifested?
4. List the overlapping areas of global health.
5. Write a short note on VHAI.
6. Name the bacteria by which leprosy is caused.
7. State some schemes and projects undertaken by the Central Social Welfare Board.

Long-Answer Questions

1. Elaborate upon the social and cultural factors affecting community health.
2. Discuss the variations in the meaning of the term 'community medicine'.
3. Examine the areas on which 'global health' focuses.
4. Explain some major functions of Voluntary Health Agencies (VHAs) in India.
5. Discuss the present activities of the Indian Leprosy Association.

6.9 FURTHER READINGS

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UNIT 7 THEORETICAL PERSPECTIVES OF HEALTH

Structure

7.0 INTRODUCTION

Medical sociology is concerned with application of various sociological theories. In this unit, we will be discussing about the various sociological perspectives or theories related to health in detail. Sociological theories involve a wide range of activities and frameworks which are derived from empirical and scientific observations and reasoning about the world.

7.1 OBJECTIVES

After going through this unit, you will be able to:

- Analyze the functional perspective on health
- Discuss the conflict approach, integrationist approach and labeling approach
- Examine the concept and ways of tackling stigma

7.2 FUNCTIONAL PERSPECTIVE ON HEALTH

One of the oldest theories in sociology is the functionalist theory. It dates back to the early works of Auguste Comte who coined the term sociology in 1839. Functionalism is a perspective which uses organic analogy in order to elaborate and explain in detail the human society and as to human beings live with each other in a particular society. Its central feature is to maintain equilibrium in society, social order as well as to maintain stability in human society. Now we need to understand

as to how functionalism grew. It grew up with the rise of empiricism, rationalism and most importantly with the coming up of scientific revolution which was seen as the turning point in sociology worldwide. Functionalism is found to be a realist tradition. For them whatever exists in society is said to be real. As such they believe that any sort of health related problem has to exist and one cannot escape from it since it's real and thereby part of the society. Apart from this point of view, functionalists also argue and believe that social processes are determined and grounded on the cause-effect principle, meaning that whatever happens in the society, happens because it is associated with some sort of cause. Furthermore, causality is also seen as an important aspect. Thereby it is only when cause is understood in a proper and systematic way that its effect can be understood. Thereby without cause there is no effect in society. Functionalism tends to hold and believe in various sorts of causalities. Human behaviour according to them is determined by social norms, values and positions, and so on.

Furthermore, Comte (1896), Spencer (1896), and Durkheim (1897) recommended that the application of scientiûc methodology should be the modus operandi of sociology. They view health as normal since it's real and see it as a prerequisite for the functioning of the society whereas they view illness as a deviance which hinders the normal day to day activities in the society.

Parsons' Sick Role

Talcott Parsons is seen as one of the oldest structural functionalists and an American sociologist. In his most well documented and famous work knows as the *social system* published in 1951, he mentions about the concept of sick role. This model was designed and formulated to explain illness behaviour. Parsons is well known for his theory on value consensus and social order and equilibrium. His major focus lies in the aspect as to how social interaction leads to the production of social order and maintains social order and stability in society. He had analyzed individual behaviour in the context of large scale social systems. However he states that if there lies a very high level and proportion of illness then it is dysfunctional for the society since it prevents people from obliging and doing their social roles in a just and fair manner.

According to Parsons, Illness is "one of the most important withdrawal behaviours in our society". He argued that it is the one who is fallen ill tends to take up on a sick role that eventually turns n to provide that individual with responsibilities. Parsons has identified four aspects of the institutionalized expectation system which is related to the sick role. These are as follows:

1. Being exempted from any sort of normal social role responsibility which is in relation to the severity of the illness. It is generally the Doctor or physician who examines and clarifies this. But many a times we find that individuals are reluctant to believe that they are sick. Thereby Parsons here justify the role of significant others which take place.

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2. Being exempted from any responsibility so as to get well and healthy by one's own actions. In Parsons' words, "... the sick person cannot be expected by 'pulling himself together' to get well by an act of decision or will.
3. The individual who is actually sick needs to accept both the state of being ill to be not desirable as well as to get well soon. Since sick person is seen as dysfunctional for the society thereby it becomes a necessity for the individual to get fit as soon as possible.
4. There lies an obligation in order to seek technically competent help, normally which is found from a physician and to cooperate with him/her in the process of trying to get well.

Criticism: Sick role theory has been criticized largely worldwide. The sick role provides a one-way obligation in the sense that it happens to recommend that the ones who are ill need to and are required to cooperate in the process of getting well. This might happen to defy the right to self-determination of the individual concerned thereby making their morale to come down. Further critics have argued that Parsons always is found to be a sole believer of the fact that recovery is always possible but one finds that since many centuries there is presence of chronic diseases that too which is taking place in large proportion which might be lifelong sometimes and the person concerned cannot be exempted from role obligation for life.

Emile Durkheim: Emile Durkheim, a well-known sociologist has seen sociology as the scientiûc study of social facts. He viewed and perceived social facts as general, coercive and external to individuals. As he noted, social facts exist sui generis— independent of the human mind.

Durkheim's work *suicide* is very widely popular and gained recognition which we will be discussing here. He deûned suicide as "all cases of death resulting directly or indirectly from a positive or negative act of the victim himself [or herself], which he [or she] knows will produce this result [i.e., death]. Egoistic suicide occurs when a person has little or no connectedness with others in the social system: the social string is weak or nonexistent. It is found as social alienation and which leads to excessive individualism. A high level of integration will lead to altruistic suicide. He talks about fatalistic suicide as well. Further, he noted and observed that suicide was found to be higher among Protestants as compared to Catholics, it was much more higher among single people, childless widows , divorced men, among whites as compared to blacks, among men than women, and in urban areas than in rural areas. Furthermore, recent studies have highlighted that suicide continues to be a major health issue among the elderly. They are more prone to it as compared to the rest of the people.

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7.2.1 Conflict Approach

Marx is widely known for the conflict approach and seen as one the most famous theorists when it comes to conflict approach. Firstly, Marx highlights on the idea that men happen to act on the outside world through means of labour. This makes a society to exist which is quite distinctive and unique, characterized by a set of distinctive set of human needs which need to be met. Secondly, Marx holds the view that something such as capital shouldn't be seen as a natural thing rather he says capital is something in which one element in a definite social relationship of production corresponding to the particular historical formation and is only manifested in things such as the spinning jenny. Furthermore, Marx states that for him all social phenomena are seen to be rational. He further states that there is no natural laws of economic life per se that are independent of given historical structures.

Further if we talk about Gerhardt's medical sociological models one finds that there is one deprivation-domination model whereas the other one is the loss model. The positive part is also noted in reference to health. He says that the deprivation model tends to talk about the population rather than individuals. The risk in terms of health and how much a person happens to live are seen to be graded and rated by social strata. In society there exists treatment as well but they might happen to include something which is labelled as 'DE medicalization' and 'deprofessioanlization'.

Furthermore, the conflict approach tends to criticize various efforts which were incorporated by physicians and Doctors in order to control the practice of medicine and to define various social problems which are seen as medical ones. On a positive side, physicians hold that they are the ones who are the most qualified professionals and they are the ones who happen to treat people who have any sort of illness and hence seen as unhealthy. But on the other hand the negative part of this also happens to exist. They also hold the view that by doing such a thing there financial status will happen to increase and improve if they treat and diagnose the problems in a correct manner. Thereby once the problems happen to become 'medicalized' their possible social roots and thus potential solutions are neglected.

Nevertheless one finds that there exists a lot of criticism of the conflict approach in terms of health and medicine. As such critics argue that in today's time alternative medicine is seen to become widely known now a days. Further eating disorders also happen to illustrate conflict theory's criticism. As such we find that there are many women and girls who tend to generate in themselves many sorts of eating disorders which they generally receive from a physician or any sort of health care service provider. Obstetrical care provides another example. Further, many hyper active children happen to develop and diagnosed with ADHD, or attention deficit/hyperactivity disorder. Thereby many critics argue on the fact that the conflict approach theorists who happen to assess health is quite harsh for people.

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7.2.2 Integrationist Approach

The integrationist approach emphasizes that health and illness are social constructions. An integrative approach begins with theory and study design. The theory advocates on the principle that one finds that there exists social environment which is found to be very important during adolescent age group since that is the time period when the young generation happen to spend time outside their family.

Furthermore, this approach in simple terms means that the various physical or mental conditions that exist tend to have no objective reality. They are found to be healthy or have any sort of illness when only the society happens to perceive them as such. Thereby this approach focuses on sickness which is seen as a social construction rather than simply seeing it as any sort of medical condition. It is further concerned with the fact that as to how people happen to develop shared meanings of health and sickness which is generally done by the continuous interactions which take place between individuals and with the larger society.

It is from this approach that one finds people to develop in themselves subjective notions of various types of sickness. Further, many times we find that there happen to exist various stereotypes and misconceptions in regard to certain conditions which happen or exist. As such for instance, it might be seen in the context of mental disorders which eventually result and lead to the creation of stigma as Goffman has discussed and talked about in great detail. Further, this approach also focuses and talks about how patients happen to cope with their sickness, be it either mental or physical. This perspective further elaborates on how such sort of patients might make sense of their identities thereby as such their identity of being a patient in any kind of health care service provider and what their idea and perception of sickness and death is. This might eventually lead to creation of empathy and understanding that when we talk about sickness it is more than just the body.

Furthermore, in the United States, one finds that the consumption of opium was quite common and well known especially in the late 1800s. The use of opium was seen neither to be a major health nor legal problem. This led to the banning up of opium in the early part of the twentieth century which was found to ban all sorts of opium products except the ones that required any kind of prescription.

Similarly, new ways of defining obesity have been devised. Obesity is a known health risk, but a "fat pride" or "fat acceptance" movement composed mainly of heavy individuals is arguing that obesity's health risks are exaggerated and calling attention to society's discrimination against overweight people. Now one finds that although such type of discriminatory act or part was found which is very much unfortunate to accept but we find that the various critics of it happen to argue that the movement has been taken too far. Furthermore, this approach happens to provide with important studies which is seen in the interaction between patients and health care service providers. One finds that the physicians or Doctors happen to manage the situation which they are living in to showcase their medical

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position and their authority professionally. Patients at most of the times are found to wait standing in line for a long period. The physician uses complex medical terms to describe a patient's illness instead of the more simple terms used by laypeople and the patients themselves.

Furthermore, there exist a lot of criticisms of this approach or perspective as well. As such one finds that critics criticize the symbolic interactionist approach for implying that no illnesses have objective reality. Many serious health conditions do exist and put people at risk for their health regardless of what they or their society thinks. Critics also say the approach neglects the effects of social inequality for health and illness. Despite these possible faults, the symbolic interactionist approach reminds us that health and illness do have a subjective as well as an objective reality.

7.2.3 Labeling Approach

The proponents of labeling approach happen to argue that it is mental illness which is seen to be manifested as a societal influence. Labelling theory in perspective of health is found to have good relations and connected in good terms with the social construction and symbolic interactionism.

It was in the year 1966 when Thomas J. Scheff published *Being Mentally Ill*: *a sociological theory* that one finds that Labeling theory was first applied to the term 'mentally ill'. The author argued and challenged upon the common perceptions of mental illness. He did so by arguing that that mental illness is manifested solely as a result of societal influence.

Society views certain actions to be deviant in society. Society most of the time happen to places the label of mental illness on those who exhibit them.

Labeling theory was formulated in 1960s by various sociologists who view that deviance is not inherent to an act. Labeling theory believes in the fact and principle that how the self-identity and behaviour of individuals may be determined or influenced by the terms used to describe or classify them. Furthermore labelling theory is closely associated with self-fulfilling prophecy.

Further, one finds that in the labeling theory, it's the social construction of deviant behaviour which is found to play an important role in it. The theory focuses on various aspects, as such it on labeling of criminally deviant behaviour along with labelling that reflects stereotyped or stigmatized behaviour of the "mentally ill" individual. Labeling theory argues that mental illness does not exist as many tend to argue upon, the theory says that it is merely deviance from the norms of society which lead to people to believe in mental illness.

There exist other issues when it comes to labelling theory. As such one issue which persists is that that exists rise of HIV/AIDS cases among gay men in the 1980s. HIV/AIDS was labelled a disease of the homosexual which made people to believe that homosexuality is deviant in the society.

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Stigma

Goffman (1963) defined stigma as 'an attribute that is deeply discrediting within a particular interaction'. For instance, cohabitation was looked down upon. For instance, cohabitation before marriage was really looked down upon in England and many parts of the world. But today it is found to be quite normal with many people actually supporting it. Similarly, it is seen in the context of marriage that marrying outside one's religion or caste is many a times frowned upon and not considered good by people. Similarly, stigma occurs in the context of health as well. For example, if we talk about mental illness and sexually transmitted diseases, one finds that they are stigmatized to a large degree. Same thing happens when diseases are serious for instance in context of cancer, or any sort of lung infection.

Further, one needs to understand that Stigmatization is often a consequence of labeling. It tends to make an individual stigmatized, being treated differently or at times even makes the person excluded from the society. For example, Jones (2012) discusses the stigmatization of working class communities in England through the 'chav' label, arguing that it contributes to perpetuating social inequalities. If we talk about stigma, we find that it might occur due to marginalization of certain sections or groups of people, it might even occur due to prevalence of fear in the minds of people. Further, media also happens to play an important role in this context. In context of health as we have already mentioned above HIV/AIDS is seen one of the diseases which is more often stigmatized and which eventually makes the person marginalized and excluded from the society where he actually used to live. Goffman argues that when any sort of disease if seen to be attached to an individual then the very label itself has the power to 'spoil the sufferer's identity'. This has a lot of consequences which are never seen as positive on the minds of the individual. As such we find that the individual concerned is often seen to have a feeling of shame, goes into a state of depression making him to withdraw from society at large and there is unwillingness of speaking up for himself or for others. Once an individual has been diagnosed as mentally ill, labelling theory would assert that the patient becomes stripped of their old identity and a new one is ascribed to them. This makes the labelled person gain a new set of identity for himself or herself and adopts in him a new set of social status.

Let us further look at the various ways in which one can tackle such kind of stigma.

1. **Legislation:** Legal framework is necessary in order for one to tackle stigma which might be of any sort. There lie a lot of advantages when it comes to legislation or legal framework. It happens to empower individuals to speak up both for themselves and for others. The major disadvantage of this instrument is that it does not alter the attitude and behaviour of people. As such, an individual who tends to have a stigmatized opinion may happen to comply with the legislation as such but at the same time the individual concerned might show unconscious stigmatising behaviour.

2. **Education:** If one is fully aware then it might be seen as one of the ways to tackle stigma. It might be possible so by in the form of various campaigns to raise awareness of illness which would lead to changing people's mind about various sorts of misconceptions and stereotypes which are present in the mind of the individual concerned. One of the most famous examples of the same is the 'Time to Change' campaign which was launched in 2009 that aims to raise awareness about mental health and illness.
3. **Language:** Stigmatizing language includes not only that which is derogatory or outwardly discriminatory, but also that which is related to labelling. For example, the term schizophrenic means that the identity of the individual is defined solely by their schizophrenia, thereby a person which is immune to schizophrenia is seen as a more appropriate alternative.
4. **Public acknowledgement:** Public acknowledgement may be seen as the problem itself or seen as an embarrassing symptoms. For example, the well-known actor and comedian Stephen Fry has endorsed the Time to Change campaign and spoken openly about his own experiences of mental illness.
5. **Treatment:** In context of health and medicine, one finds that the ongoing advancement in management of health conditions might contribute in the reduction of visible signs which might lead to the creation of any stigma either related to physical characteristics or features or to the behaviour of an individual. Further, there exists a lot of controversy over the fact around intervening when the intended benefit is solely to reduce stigma – for example, the use of cosmetic surgery to 'correct' the facial features of children with Down syndrome, where the surgery carries physical risks with no medical benefits. There is also present debate and concern over the question as to what is medical benefit. For instance, many people are of the view and reject the notion that medical view of deafness is seen as an impairment or disability, instead they claim that it is a culture and identity which is based upon on a trait.

Check Your Progress

1. What is functionalism?
2. How do Comte, Spencer and Durkheim view health?
3. How does egoistic suicide occur?
4. Which principle does the integrationist approach advocate?
5. When was labelling theory first applied to the term 'mentally ill'?

7.3 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

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1. Functionalism is a perspective which uses organic analogy in order to elaborate and explain in detail the human society and as to human beings live with each other in a particular society.
2. Comte (1896), Spencer (1896), and Durkheim (1897) view health as normal since it's real and see it as a prerequisite for the functioning of the society whereas they view illness as a deviance which hinders the normal day to day activities in the society.
3. Egoistic suicide occurs when a person has little or no connectedness with others in the social system: the social string is weak or nonexistent. It is found as social alienation and which leads to excessive individualism.
4. The integrationist approach advocates on the principle that one finds that there exists social environment which is found to be very important during adolescent age group since that is the time period when the young generation happen to spend time outside their family.
5. It was in the year 1966 when Thomas J. Scheff published *Being Mentally Ill*: *A Sociological Theory* that one finds that labeling theory was first applied to the term 'mentally ill'.

7.4 SUMMARY

- Functionalism is a perspective which uses organic analogy in order to elaborate and explain in detail the human society and as to human beings live with each other in a particular society. Its central feature is to maintain equilibrium in society, social order as well as to maintain stability in human society.
- Functionalism is found to be a realist tradition. For them whatever exists in society is said to be real. As such they believe that any sort of health related problem has to exist and one cannot escape from it since it's real and thereby part of the society.
- Parsons is well known for his theory on value consensus and social order and equilibrium. His major focus lies in the aspect as to how social interaction leads to the production of social order and maintains social order and stability in society.

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- Sick role theory has been criticized largely worldwide. The sick role provides a one-way obligation in the sense that it happens to recommend that the ones who are ill need to and are required to cooperate in the process of getting well. This might happen to defy the right to self-determination of the individual concerned thereby making their morale to come down.
- Durkheim's work *suicide* is very widely popular and gained recognition in which he deûned suicide as "all cases of death resulting directly or indirectly from a positive or negative act of the victim himself [or herself], which he [or she] knows will produce this result [i.e., death].
- Marx holds the view that something such as capital shouldn't be seen as a natural thing rather he says capital is something in which one element in a definite social relationship of production corresponding to the particular historical formation and is only manifested in things such as the spinning jenny.
- The integrationist approach emphasizes that health and illness are social constructions. An integrative approach begins with theory and study design. The theory advocates on the principle that one finds that there exists social environment which is found to be very important during adolescent age group since that is the time period when the young generation happen to spend time outside their family.
- Critics criticize the symbolic interactionist approach for implying that no illnesses have objective reality.
- Labeling theory was formulated in 1960s by various sociologists who view that deviance is not inherent to an act. Labeling theory believes in the fact and principle that how the self-identity and behaviour of individuals may be determined or influenced by the terms used to describe or classify them.
- The labeling theory focuses on various aspects, as such it on labeling of criminally deviant behaviour along with labelling that reflects stereotyped or stigmatized behaviour of the "mentally ill" individual.
- One needs to understand that Stigmatization is often a consequence of labeling. It tends to make an individual stigmatized, being treated differently or at times even makes the person excluded from the society.
- In context of health and medicine, one finds that the ongoing advancement in management of health conditions might contribute in the reduction of visible signs which might lead to the creation of any stigma either related to physical characteristics or features or to the behaviour of an individual.

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7.5 KEY WORDS

- **Functionalism:** It is a viewpoint of the theory of the mind. It states that mental states are constituted solely by their functional role, which means, their causal relations with other mental states, sensory inputs and behavioural outputs.
- **Causality:** It is influence by which one event, process, state or object (a cause) contributes to the production of another event, process, state or object (an effect) where the cause is partly responsible for the effect, and the effect is partly dependent on the cause.
- **Labeling Theory:** It posits that self-identity and the behavior of individuals may be determined or influenced by the terms used to describe or classify them.
- **Symbolic Interactionism**: It is a sociological theory that develops from practical considerations and alludes to people's particular utilization of dialect to make images and normal implications, for deduction and correspondence with others.

7.6 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. How did functionalism grow?
2. Name Parson's work in which he mentions the concept of 'sick role'.
3. What does the major focus of Parson lie on?
4. Why has Parson's sick role theory been criticized?
5. What is the major disadvantage of legislation for tackling stigma?

Long-Answer Questions

1. Discuss the views and beliefs of functionalists.
2. Analyze the four aspects of the institutionalized expectation system which is related to the sick role.
3. Elaborate upon Marx's conflict approach.
4. Discuss the ways in which one can tackle stigma.

7.7 FURTHER READINGS

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BLOCK - III
SOCIAL EPIDEMIOLOGY: MEANING AND DEFINITION, NATURAL HISTORY OF DISEASES, HOSPITAL AND HEALTH PROFESSION IN SOCIETY

UNIT 8 SOCIAL EPIDEMIOLOGY

Structure

8.0 INTRODUCTION

While epidemiology is concerned with the distribution, patterns and determinants of diseases, social epidemiology is concerned with the study of social structures and characteristics that affect the health scenario in a society and its mechanisms. It studies health and diseases in a population and the prevalence as well the incidence of epidemics in particular societies and the morbidity rates associated with them.

8.1 OBJECTIVES

After going through this unit, you will be able to:

- Analyze the concept and scope of social epidemiology
- Discuss the uses and sources of vital and health statistics
- Describe the different types of epidemiological methods

8.2 MEANING, DEFINITION AND COMPONENTS OF EPIDEMIOLOGY

The word epidemiology was first coined by Hippocrates. It has been derived from two Greek words: ***epi*** meaning upon and ***demos*** meaning people; which meant ‘what is upon the people’. This naturally interested the early physicians, as they sought to designate by a special word, the large number of persons or groups

of people in any locality, who were afflicted by the same disease at about the same time, as if the disease came upon them as wrath of the Gods; and consequently, caused great public alarm and panic, as death occurred in large number of cases simultaneously. The study of epidemic was, therefore, designated epidemiology and these persons as epidemiologists; and it embraced the study of not only the causes, but also the consequences of epidemic diseases; and both together, to devise methods for their control. "An epidemiologist is an investigator who studies the occurrence of disease or other health-related conditions or events in the defined population." (Last, 2001)

Hippocrates, the father of medicine, discusses the relationship between occurrence of disease and the physical environment. For example, the cases of disease fitting the description of malaria were found to occur in the vicinity of marshy land and swamps. There are epidemics of plague during different periods in past. There were also epidemics of leprosy, small-pox, malaria, yellow fever, and syphilis. Cholera, a major epidemic occurred in England as well as in India. Many people died because of these epidemics. John Snow's quashing of the London cholera epidemic in 1954 is a classic example of how epidemiological methods can be used to limit disease and deaths. His achievement was even more remarkable because it occurred 30 years after Louis Pasteur proposed his 'germ theory of disease'. It was not until 1883 that Robert Koch discovered the bacteria that causes cholera, bacterium *vibrio cholerae*. From this early use for the description and investigation of communicable disease, epidemiology has developed into a logical field of science. Epidemiological methods are used to evaluate everything from the effectiveness of vaccines to the possible causes of occupational illnesses and unintentional injury deaths.

Social Epidemiology

Epidemiology is the study of health and diseases in the population in a society, and is concerned with the amount and types of epidemic or endemic diseases that affect communities; their incidence and prevalence in different population groups, in relation to their total environmental situations, including ways of life and living; and the mortality and morbidity to which they give rise and incapacitate them. Epidemiology is the common and main approach to both preventive as well as social medicine.

Social epidemiology is that branch of epidemiology concerned with the way that social structures, institutions and relationships influence health.

Contemporary approaches favour a multi-causal and process model of the way an individual stays well or becomes ill. The attack is multi-causal because the health states of most compelling interest appear to rest on a concatenation of biological vulnerability, psychological dynamics, ecological causes, and social situational expectations. It is processual because an illness is not conceived as a single event that impinges on a stationary organism but, instead, as a sequence of malfunctions, phased in and out with the exigencies of experience as individuals

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and families move along the arc of life. The current thrust of social epidemiology may be phrased as an effort to assess the links between the lifestyles of populations, their total configuration of actions and reactions in social times and space, and the health risks to which those populations are vulnerable. In this thrust, investigators clearly require a conceptual model of causation that goes beyond the germ theory of disease and that pays as much attention to social, ecological, and psychological agents as to microorganisms. The older medical rhetoric—what's he got and what's good for it?—is giving way to a much more complicated question, or series of questions, that might be put thus: What is it about his way of life that cushions or exacerbates certain health risks, and how may he/she be helped to live with the burden of chronicity?

Epidemiologists are concerned with numbers. Numbers are related with health events like number of cases (i.e. people who are sick), and number of deaths. Although, these numbers alone are not sufficient to provide an analysis of disease of community, epidemiologists must know the total number in the susceptible population so that rates can be calculated. A rate is the number of events, i.e. birth, cases of disease, or deaths in a given population over a given period or at a given point in time. These general categories of rates are natality, birth rates, morbidity (sickness) rates, and morality or fatality (death) rates. Why are rates important? Why not simply enumerate the sick or dead? The answer is that rates enable one to compare outbreaks that occur at different times or in different places. For example, by using rates it is possible to determine whether there are more cases of dengue per capita this year than there were last year or whether there are more cases of AIDS cases per capita in southern India than northern India.

Scope of Epidemiology

It is clear from the above, that the major tasks of epidemiologists are to study and describe the following:

- Patterns of diseases, either as epidemics or endemics
- Whether confined to small groups in communities, in rural or urban areas; or widespread over large section of the society
- How they recur in certain seasons of the year, or exhibit cyclical variations once in five or seven-year periods by study of seasonal and long-time trends
- Whether they occur in certain age-groups, sex-groups, or occupation groups
- Whether they are caused by loss of immunity in the human host or, increase in numbers or, greater contacts with the intermediary host, or reservoir hosts, and interactions between all these together
- Increased virulence or new strains of the bacterial, or virus agents and the like, assisted by physical, chemical and mechanical agents, which assist transmission of infection to human hosts

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- Variations in the environmental factors including physical factors and social conditions such as customs, habits and living conditions, which tend to bring all the above factors together, throwing their weight and balance against the human host, and upsetting the natural equilibrium of health towards disease status (Gladston, 1953).

Thus, epidemiology is concerned with the study of several variations in the pattern and distribution of diseases, which determine their incidence and prevalence of cases and deaths among groups of population both in time and place; to devise priorities and targets in health programmes, determine strategy and techniques in their effective and economical prevention and control, suggest suitable administrative machinery and organization including social strategies; and finally assess their uses to the group or community they serve.

Components of Epidemiology

The components of epidemiology essentially refers to the epidemiologic triangle. The epidemiologic triangle is made up of three parts: agent, host and environment. These are:

(i) Agent

The agent is the microorganism that actually causes the disease in question. An agent could be some form of bacteria, virus, fungus, or parasite.

(ii) Host

The agent infects the host, which is the organism that carries the disease. A host doesn't necessarily get sick; hosts can act as carriers for an agent without displaying any outward symptoms of the disease. Hosts get sick or carry an agent because some part of their physiology is hospitable or attractive to the agent.

(iii) Environment

Outside factors can affect an epidemiologic outbreak as well; collectively these are referred to as the environment. The environment includes any factors that affect the spread of the disease but are not directly a part of the agent or the host. For example, the temperature in a given location might affect an agent's ability to thrive, as might the quality of drinking water or the accessibility of adequate medical facilities.

Check Your Progress

1. Give one example of effective use of epidemiological methods to limit disease and death.
2. How can the current thrust of social epidemiology be phrased?
3. Why are rates important? Give an example.

8.3 VITAL STATISTICS: USES AND SOURCES OF VITAL AND HEALTH STATISTICS

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Epidemiologists must know the total number in the susceptible population so that rates can be calculated. To calculate the rate, epidemiologists required data regarding the types of morbidity rates, and these include incidence rates, prevalence rates, and attack rates. An incidence rate is defined as the number of new health-related events or cases of a disease in a population exposed to that risk in a given time period- the number of new cases of dengue in a given population over a month's time. For example, those who became ill with dengue during the previous month and remained ill during the month in question are not counted in an incidence rate. Incidence rates are important in the study of acute diseases, diseases in which the peak severity of symptoms occurs and subsides within days or weeks. These diseases usually move quickly through a population. Examples of acute diseases are the common cold, chicken-pox, diarrhoea, measles etc. Prevalence rates are calculated by dividing all current cases of a disease (old and new) by the total population. Prevalence rates are useful for the study of chronic disease, diseases that usually last three months or longer. In the cases of chronic diseases it is important to know that how many people are suffering from chronic diseases like arthritis, heart disease, cancer or diabetes and to know when they became inflicted. Although it is difficult to determine the date of onset of these chronic diseases, as the sufferers of these chronic diseases use health services and facilities. Thus, prevalence rates are more useful than incidence rates for the planning of public health programmes, personnel needs, and facilities.

An attack rate is special incidence rate calculated for a particular population for a single disease outbreak and expressed in percentage. For example, suppose a number of people attending a marriage party fall ill after eating food over there. After some time, all the people who attended the party develop some sort of gastric problem. Immediately the epidemiologists suspected that the cause of illness is something to do with the food served in the marriage party. An attack rate could be calculated for the people who attended the marriage party to express the percentage who became ill. Furthermore, the attack rate can be calculated on the basis of who ate what in the party. Difference in the attack rates for different sub-population groups might indicate to the epidemiologists the source or cause of the illness. Furthermore, incidence and prevalence rates can be expressed in two forms, i.e. crude and specific. Crude rates are those in which the denominator includes the total population. The most important of these are the crude birth rate and crude death rate. Crude birth rate is the number of live births in a given year, divided by the mid-year population. The crude death rate is the total number of deaths in a given year from all causes, divided by the mid-year population. Specific rates measure morbidity and mortality for particular populations or for particular disease. One could calculate the age-specific mortality rate for a population of 0–5 years by dividing the number of deaths in that age group by the mid-year population

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of 0–5 years old. Similarly, one can also calculate the class and sex-specific mortality rates. Cause-specific morality rate is used to measure the deaths rates for a specific disease. This rate can be calculated by dividing the number of deaths due to a particular disease by the total population. Similarly one can also calculate an age-specific, cause-specific mortality rate. Case fertility rate and the proportionate mortality ratio are also used for measuring the disease. The case fertility is simply the percentage of cases that result in disease agent. It is calculated by dividing the number of deaths from a particular disease in a specified period of time by the number of cases of that same disease in the same time period. The resulting fraction is multiplied by 100 and is reported as a percentage. The proportionate mortality ratio is described the relationship between the number of deaths from a specific cause to the total number of deaths attributable to all causes. It is calculated by dividing the number of deaths attributed to a particular disease by the total number of deaths from all causes in the same population during the same period of time. The rate is also reported as percentage.

Epidemiological Methods

Epidemiological methods are procedures for finding things out, by asking questions that cannot be asked in clinical study; about the health of the community and of the sections of it, present and past; by setting clinical problems in community perspective; describing their behaviour as group, not individual phenomena; and how much and where action is needed; by revealing problems and indicating where among the population these might at best be studied. Epidemiological methods fall broadly under two heads: descriptive and constructive and each subdivided into clinical and field studies. The former is concerned with collection and analysis of data which is later on treated by statisticians, and the latter to build up constructive lines and approaches, as a contribution to preventive and social medicine. Epidemiologic studies generate data, which are derived from surveys conducted in the community. The design of such surveys depends on the specific need or purpose for which data are required. In some cases, only descriptive data on the frequency and distribution of the disease may be all that is required. Such studies are included in the term descriptive epidemiology. On the basis of such descriptive epidemiology observations, physician may be able to develop hypotheses which can then be tested in the field or community, by other epidemiologic techniques, which are based on careful analysis of differences in the cases and controls. The latter type of epidemiologic technique is called analytic epidemiology. Analytic epidemiology studies may also be carried out to evaluate the effectiveness or otherwise of preventive health measures undertaken in the community.

Descriptive Epidemiology

Descriptive epidemiology studies generate the following types of information.

- When does the disease occur? Its distribution related to the time, month, season or year.

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- Where does the disease occur? Its distribution related to place or geographic era.
- Who are the individuals, most likely to suffer from the disease, such as sex, occupation, socio-economic status, living conditions and quantitative variables such as age, income and educational attainments of the affected persons.

Descriptive epidemiology surveys provide information useful for classification of disease, developing hypotheses on the etiology of diseases and generate data for the planning of health services based on the prevalent health problems, target groups, and estimated health needs. Descriptive epidemiology surveys could be conducted either in a cross-sectional or longitudinal manner. In cross-sectional studies, observations are made at a point of time only and are not repeated. In longitudinal studies, same patients are observed repeatedly at specified points over a long period of time.

Analytic Epidemiology

As outlined earlier, a hypothesis on the possible causative factors in the etiology of the disease is developed on the basis of descriptive epidemiology. The hypothesis can then be put to test by two approaches:

(i) A group of patients and controls are compared with respect to the presence or absence of the possible etiological factors in them.

(ii) A population group exposed to a noxious factor is compared with a control population group not exposed to such factor, and occurrence of the disease in the two groups is recorded.

Since such studies analyze the observations made in the community and then suitable conclusions are drawn, these are termed analytical epidemiological studies. Analytical epidemiological studies could be of two types, viz., (i) case control studies, and (ii) cohort studies. Case control studies are exploratory in nature and can be completed in a relatively short period. These are relatively inexpensive. It is conducted carefully without a bias and give productive, useful information, which may form good basis for further studies. Cohort studies are often to evaluate the effectiveness of health services and to further confirm the etiological basis of the disease. The studies are always longitudinal and therefore, take several years to complete. These are fairly expensive. If the chance of an occurrence of a disease or health problem on exposure to the offending agent is minimal or if the expected benefit from the proposed health measure is marginal, cohort studies should be conducted on a fairly large sample and with decision to arrive at meaningful and statistically significant conclusions.

Experimental Epidemiology

Experimental studies are carried out in order to identify the cause of a disease or to determine the effectiveness of a vaccine, therapeutic drug, or surgical procedure. The central argument of experimental studies is that the investigator controls the

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intervention of variable of interest. In some analytical epidemiology studies, the environment is manipulated or controlled for testing hypotheses. In the experimental studies, the subjects may be humans but are often animals such as laboratory mice, rats, or monkeys. Controlling variables, the use of treatment and control groups, randomization and blinding are techniques aimed at ensuring objectivity and avoiding bias in experimental results that accurately reflect what occurs in a natural setting.

Clinical Epidemiology

When periodic observations on patients with a wide spectrum of clinical manifestations of the disease are made over a long period of time, a complete profile of the natural history of disease may be obtained. These form the basis of clinical epidemiology.

All the above mentioned types of epidemiology studies are distinct with a specific purpose or objective. These cannot replace each other. It is wrong to assume that only a large cohort or prospective study done in the community can give useful information. Carefully planned case-control studies may provide very useful information necessary for developing hypotheses on the etiology of the disease.

Check Your Progress

4. Define 'incidence rate'.
5. How can we calculate the age-specific mortality rate for a population?
6. What is the information provided by descriptive epidemiology useful for?

8.4 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. John Snow's quashing of the London cholera epidemic in 1954 is a classic example of how epidemiological methods can be used to limit disease and deaths.
2. The current thrust of social epidemiology may be phrased as an effort to assess the links between the lifestyles of populations, their total configuration of actions and reactions in social times and space, and the health risks to which those populations are vulnerable.
3. Rates are important because they enable one to compare outbreaks that occur at different times or in different places. For example, by using rates it is possible to determine whether there are more cases of dengue per capita this year than there were last year or whether there are more cases of AIDS cases per capita in southern India than northern India.

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4. An incidence rate is defined as the number of new health-related events or cases of a disease in a population exposed to that risk in a given time period-the number of new cases of dengue in a given population over a month's time.
5. We can calculate the age-specific mortality rate for a population of 0–5 years by dividing the number of deaths in that age group by the mid-year population of 0–5 years old.
6. Descriptive epidemiology surveys provide information useful for classification of disease, developing hypotheses on the etiology of diseases and generate data for the planning of health services based on the prevalent health problems, target groups, and estimated health needs.

8.5 SUMMARY

- The word epidemiology was first coined by Hippocrates. It has been derived from two Greek words: ***epi*** meaning upon and ***demos*** meaning people; which meant 'what is upon the people'.
- The study of epidemic was designated epidemiology and these persons as epidemiologists; and it embraced the study of not only the causes, but also the consequences of epidemic diseases; and both together, to devise methods for their control.
- John Snow's quashing of the London cholera epidemic in 1954 is a classic example of how epidemiological methods can be used to limit disease and deaths. His achievement was even more remarkable because it occurred 30 years after Louis Pasteur proposed his 'germ theory of disease'.
- Contemporary approaches favour a multi-causal and process model of the way an individual stays well or becomes ill. The attack is multi-causal because the health states of most compelling interest appear to rest on a concatenation of biological vulnerability, psychological dynamics, ecological causes, and social situational expectations.
- Epidemiologists are concerned with numbers. Numbers are related with health events like number of cases (i.e. people who are sick), and number of deaths.
- The general categories of rates are natality, birth rates, morbidity (sickness) rates, and morality or fatality (death) rates.
- Prevalence rates are calculated by dividing all current cases of a disease (old and new) by the total population. Prevalence rates are useful for the study of chronic disease, diseases that usually last three months or longer.
- An attack rate is special incidence rate calculated for a particular population for a single disease outbreak and expressed in percentage.

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- Crude birth rate is the number of live births in a given year, divided by the mid-year population. The crude death rate is the total number of deaths in a given year from all causes, divided by the mid-year population.
- The case fertility is simply the percentage of cases that result in disease agent. It is calculated by dividing the number of deaths from a particular disease in a specified period of time by the number of cases of that same disease in the same time period.
- Descriptive epidemiology surveys could be conducted either in a cross-sectional or longitudinal manner. In cross-sectional studies, observations are made at a point of time only and are not repeated. In longitudinal studies, same patients are observed repeatedly at specified points over a long period of time.
- Analytical epidemiological studies could be of two types, viz., (i) case control studies, and (ii) cohort studies.
- When periodic observations on patients with a wide spectrum of clinical manifestations of the disease are made over a long period of time, a complete profile of the natural history of disease may be obtained. These form the basis of clinical epidemiology.

8.6 KEY WORDS

- **Epidemiology:** It is the study and analysis of the distribution, patterns and determinants of health and disease conditions in defined population.
- **Natality:** It is the ratio of the number of births to the size of the population; birth rate.
- **Germ Theory of Disease:** It states that microorganisms known as pathogens or "germs" can lead to disease. These small organisms, too small to see without magnification, invade humans, other animals, and other living hosts.
- **Etiology:** It the study of the cause, set of causes, or manner of causation of a disease or condition.

8.7 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. What is epidemiology concerned with?
2. What is a 'rate'?

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3. How is prevalence rate calculated?
4. What are descriptive and constructive epidemiological methods concerned with?
5. Write a short note on experimental epidemiology.

Long-Answer Questions

1. Discuss the major tasks of epidemiologists.
2. Analyze the definition and types of epidemiological methods.
3. Elaborate upon the two types of Analytical epidemiological studies.

8.8 FURTHER READINGS

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UNIT 9 DISEASES

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Structure

9.0 INTRODUCTION

Natural history of disease is the progression or development of a disease in an individual over a period of time which is divided into four stages namely stage of susceptibility, pre-symptomatic disease, clinical disease and reduced capacity. These stages entail the natural course that the progression of a disease usually follows. Diseases can be transmitted through various means such as direct, indirect and vector transmission which have further sub-categories. In this unit, the microbial theory or germ theory of disease has been discussed in addition to the effect that socio-cultural factors, beliefs and superstitions have on the perception of diseases and their treatment.

9.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the four common stages in natural history of diseases, the disease pattern of population and the spectrum of diseases
- Analyze the concept of social etiology
- Describe the microbial theory and the means of transmission of diseases
- Understand the socio-cultural factors bearing on health in India

9.2 NATURAL HISTORY OF DISEASES

The natural history of disease is the uninterrupted progression in an individual of the biological development of disease from the moment that it is initiated by exposure

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to the casual agents.' In case of the contact with an external agent there are four types of outcomes as depicted by Figure 9.1 (b):

- There will be no change after interaction with the agent, perhaps because:
  - o Dose of exposure was very low
  - o The host was not susceptible to the agent
- Damaging effect of agent can be cured
- Illness occurred but is controlled by the body due to strong immune system
- Illness progresses and ends in an irreversible dysfunction or demise.

The result will rely on the interplay between the host, the agent, and the environment. In case of any intervention in terms of prevention or treatment, it will be called the natural history of a disease. Natural history, outlined by the above mentioned four outcomes is a concept of utmost interest to medical studies, including epidemiology. Individuals living a healthy life, free from any disease is an ideal concept, in actuality, they are likely to get exposed to various agents, some of which can be disease causing. All of this collectively increases susceptibility to disease and burden of the disease as depicted by Figure 9.1 (a).

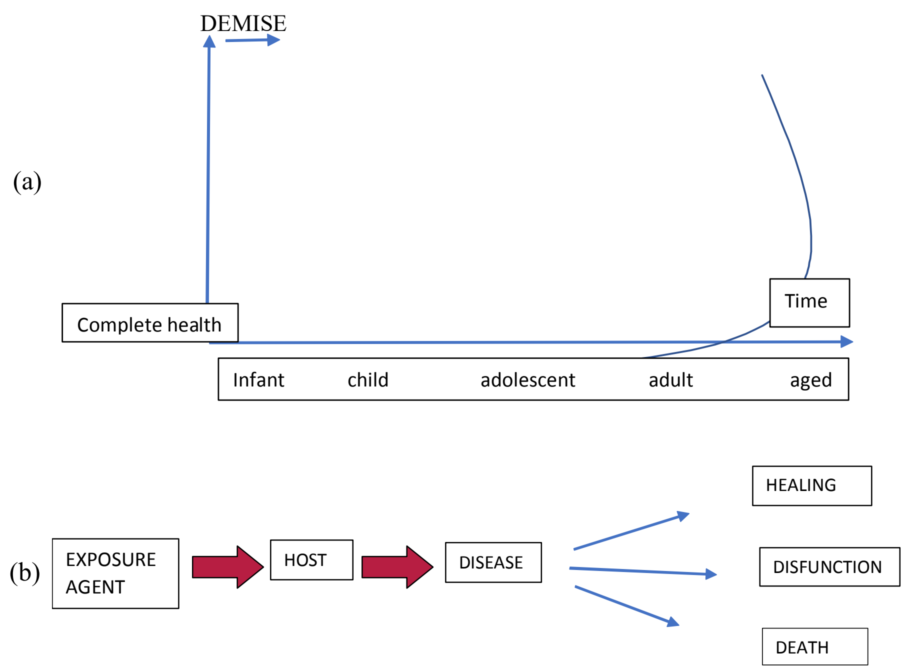


Fig. 9.1 (a) Natural Progression of Disease in a Healthy Person (b) Likely Outcomes with Interaction between an Agent, Host, and Environment

In practice, natural history of a disease is difficult to study as the process is interjected, either by treatment modality or immunisation. The information about natural history of many diseases is not known because:

1. Diagnosis and follow up by a clinician can lead to changes in the disease progression

2. The objective of observing a disease process clashes with ethical principle to alleviate, contain, or treat the disease.

The concept of epidemiological studies of natural history states that the studies can be carried out only with the consent of the individuals. Studies are allowed when there was no treatment modality applied for that condition. If during the course of conducting the study, a successful treatment is discovered, then the study will be discontinued or altered. The control group of study is provided with the most effective treatment available, while the other one is studied using Cohort studies or follow up studies for studying the natural course of disease. Repeated collection of data from the same subjects is compulsory in chronic diseases.

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Four Common Stages in Natural History

There are four stages in the natural progression of a disease:

- Stage of Susceptibility
- Stage of Pre-symptomatic disease
- Stage of Clinical disease
- Stage of Reduced capacity

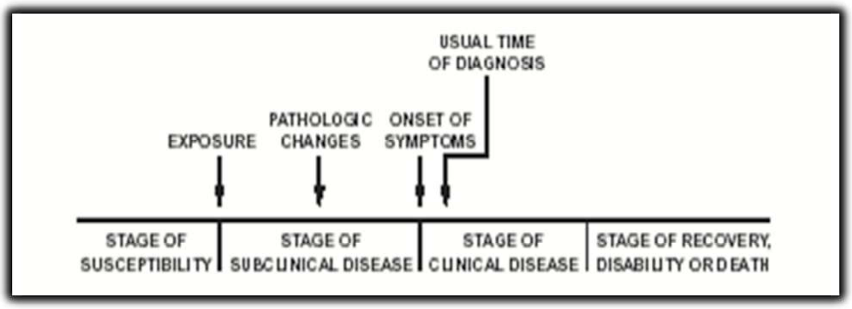


Fig. 9.2 *Common Stages in Natural History*

Susceptibility stage

This stage proceeds with the start of any disease. The disease has not yet started, but the host is vulnerable because of the existence of risk factors related to the disease. For example, individuals exposed to sun rays for a prolonged period of time will have more chances of having skin cancer.

Pre-Symptomatic disease stage

By this stage, the pathological changes have started in the body, but there is absence of signs and symptoms. In communicable diseases, this phase is called an incubation period, which is the 'time period between the invasion of an infectious disease agent and the development of first signs or symptoms of the disease'. It varies greatly from individual to individual. Diseases having long incubation periods are called Late Onset Diseases. The term is formulated after observation of natural

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history in many individuals, not on the basis of clinical route in an individual. The chances to prevent a chronic disease also get extended.

When incubation span ranges few days, few weeks, and sometimes month, the diseases are called Early Onset Diseases**.** An acute disease can have irreversible (chronic) effects. The Figure 9.3 depicts the types of incubation period, where A, inclined to the left, represents short incubation span and B, inclined to the right, represents long incubation span.

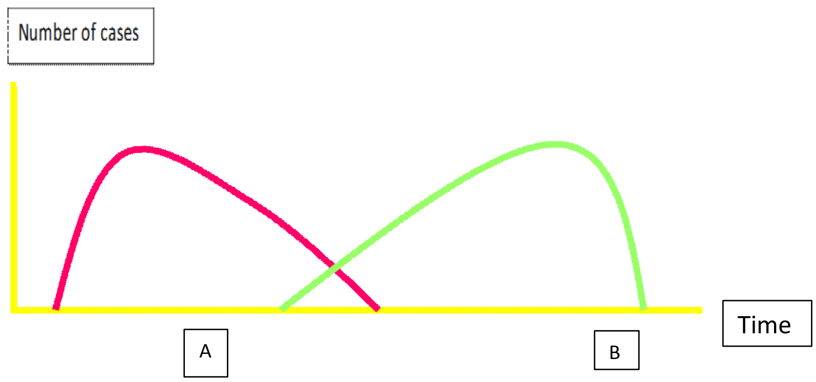


***Fig. 9.3** Types of Incubation Period in Disease Outbreak*

Incubation period depends on:

- Portal of entrance into the host
- The capability of multiplication
- Quantity of agent
- Amount of antibody in the host

In non-communicable disease, this stage includes the latency period, which can be defined as the period from disease initiation to disease detection. In addition, the stage of susceptibility also includes the subclinical disease that is a disease which is fully developed but produces no overt signs or symptoms in the host.

Clinical Disease Stage

By this stage, the condition is distinctly apparent and the host encounters one or more noticeable signs or symptoms, typical of the disease. This stage involves diagnosis and treatment by clinician. Clinical disease may vary in terms of extremity and will progress slowly or rapidly depending upon host, agent and environmental factors.

Reduced Capacity Stage

The final stage of natural history of disease is characterized by a convalescent period or a residual disability. In the case of convalescence, there is a period following completion of clinical disease, during which the individual has not yet returned to his or her former level of health. Many moderate to serious infections require some convalescence after the disease has run its course. The convalescent

period represents the time taken by recovered individuals to get back on their feet, while residual disability refers to the development of complications or disability resulting directly from the clinical disease.

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The information about natural history is important for devising disease prevention strategies, particularly for secondary prevention based on screening of the individuals. The natural history is useful in individual cases and has important implications on public health. Its importance lies with the fact that:

- Alterations in natural history in individuals affect the population pattern.
- Various paths of progression in different individuals provide knowledge about alternatives that can be utilized in a population at large.

The Disease Pattern of Population

Natural history and population pattern of a disease are interconnected in the following ways:

(a) **Susceptibility:** Decreased susceptibility will lower the cases diagnosed with disease, thereby decreasing the frequency of disease, whereas increase in susceptibility will lead to increase in frequency of disease. The length of the disease depends on the susceptibility of individuals and their ability to fight back.

(b) **Span of a disease:** A shorter span has better prognosis, with morbidity and mortality rates. Prevalence rate will be affected but incidence rate would not.

(c) **Incubation span:** The duration of incubation period has an influence on disease patterns of population.

(d) **Adversity of disease:** The adversity of a disease can change depending on altered virulence of an agent or susceptibility of the host, which will affect the incidence and prevalence.

Spectrum of Disease

An exposure to the same disease can have varied manifestations in different individuals; this is known as disease spectrum. Spectrum of a disease denotes the idea that a disease may present itself with varied signs, symptoms, and complications. The objective is to find the nature and causative factors responsible for variation, estimate the progression of disease in cluster population, and make authentic predictions of consequences at both, individual and at population level. For example, 100 people are exposed to a Legionnaires bacillus; around 90% will show no perceptible problems. The remaining population will have mild influenza episode to severe pneumonia. The mortality rate will be high in some population groups. The incubation period will vary greatly. People survived will either recover completely or have some dysfunction. The disease spectrum signifies the variability in the nature of a disease, while natural history denotes progression of a disease.

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Check Your Progress

1. What does the 'natural history of disease' refer to?
2. What does incubation period depend upon?
3. What is disease spectrum?

9.3 SOCIAL ETIOLOGY

The term social etiology is a combination of two different subjects-medical science and sociology. The first part is about the social factors that influence health and the second is about the cause of a disease.

The etiology of a disease refers to its cause or its origin. Etymologically, etiology is also the name for the study of the causes of diseases. It may also refer to the study of the cause of things in other fields like sociology.

Illness and diseases often have their roots entrenched in factors that are social in nature. These factors act as catalysts and they inevitably lead to ill-health and diseases that afflict individuals.

Dahlgren and Whitehead's (1991) have significantly contributed to illustrating the wider determinants of health. Their study effectively represents how various individual, social, economic, and cultural factors have a direct bearing on the inequalities in health and illness. Various studies point towards the fact that mental illness may be linked to individual risk factors such as age, sex, or genetics. Lifestyle factors influence these and in turn, they are affirmed by social and community networks and relationships. Living and working conditions have a direct bearing on health issues and they are further impacted and are influenced by the broader socioeconomic and cultural contexts. Health beliefs do not form a direct part of this model, but research suggests that they are crucial when individuals process and act upon health information. Broader implications of how resilience, susceptibility, and response to mental ill-health are developed evolve out of this.

The above facts serve to remind us about the undeniable importance of social and economic determinants of health. It is a fact that a low standard of living and absolute poverty bordering on penury have a devastating impact on the health of the people of developing countries. The knowledge that life factors are inexorably linked to social and economic structures as much as they are genetically determined makes the study and exploration of health and social factors a social science. This in essence is what Social Etiology is about.

'Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age.' (Marmot, 2010)

The key pointers to mental and physical health are childhood and early life experiences. Adverse childhood events can sow the seeds of poor health in adult

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life. Factors that may seem unconnected like abuse, deprivation, domestic violence, and parental divorce can deeply impact health. However, it is not that all people who experience undesirable events during childhood are afflicted with health problems. If such factors as education, family bonding, feeling loved and cared for are experienced then individuals form resilience to adversities and are thus better equipped to handle difficult and stressful circumstances. Throughout life, various social connections and bonding help to mitigate depressions and other mental and physical health afflictions. Working-age adults are better equipped to handle health consequences if they are in regular employment than when they are unemployed.

9.4 SOCIAL EPIDEMIOLOGY AND ECOLOGY OF DISEASE

How variations in age, sex and occupation groups, seasonal or cyclical variations impact epidemic or endemic diseases and how far they influence mortality and morbidity patterns are described below:

1. Age-sex and occupation groups

Infectious diseases are common among early age groups, and degenerative diseases among older age-groups, while some like tuberculosis and cancer are common among adolescents and adults. However, the age distribution of mortality does not necessarily follow the morbidity patterns; generally, mortality and morbidity curves are U-shaped, with increase at the two ends of life; while in certain diseases the morbidity curve may be reversed, due to increased strains and stresses of middle-aged occupational groups. Again, the case-morality rates vary with age and sex groups; as for example pneumonias, dysenteries and certain virus and eruptive fevers which are fatal among the younger age groups, while typhoid and typhus fevers are much milder. Fractures are much more serious among older age-groups, as also coronary heart disease, diabetes and kidney disease which tend to be fatal among the old. Further, the age of the patient may determine the clinical type of the disease and these types may change again among the occupation groups and each vary from time to time, with changing structure of society and economic conditions; such as diabetes and hypertension which are becoming more common at much younger ages.

2. Seasonal, cyclical and space variations

Among epidemics, water-borne infections like cholera, typhoid and dysentery follow the wake of the monsoons and several insect-borne diseases are subject to seasonal variations. Further, all endemic diseases caused by insects such as plague, typhus and relapsing fever are seasonal, as insects populations vary with metrological seasons.

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3. Mortality and morbidity

Mortality data are in their very nature more accurate than morbidity, as deaths occurs only once for any person. In acute killing diseases, mortality rates will give a fair picture of the distribution and their relative importance, but for mild and relatively non-fatal illnesses, such as common-cold, eruptive fevers among children, asthma and rheumatoid arthritis, deaths are a poor description of their frequency and distribution. In the same disease, there may be differences; as mortality data can be used for *p.falciparum* malaria which is a killing disease, but not for *p.vivax* or quartan malaria, where morbidity would be more appropriate.

4. Infectious diseases

Registration of sickness is generally limited to notifiable infectious diseases, as it is compulsory, for early information to public health departments, taking necessary action. However, this does not happen all the time, as the responsibility for notification rests with the head of the family or individual.

Ecology and Disease

Since the triad of agent, host, and environment comprises its traditional core, epidemiology can be described as that aspect of human ecology that relates to the states of health and disease. Epidemiology is the "science concerned with the health of the populations or communities. The compass of this science is to describe states of health and their variation, to discover the determinants of the variations observed, and to use what is discovered to devise and test ways of preventing and controlling ill health." In literature, the earliest recognition of the role of the environment can be found in the Hippocratic writings, in the treatise *Airs, Water, and Places*. Here, one finds everything from physique and fecundity to sexual and war-like temperament ascribed to the influence of the purity of water and violence of seasonal change. Since that time, *personae medicae* of all persuasions—court physician and itinerant healer, philosopher and empirick, chronicler of epidemics and tender of "fluxes, argues, botches and boils", modern scientist and traditional herbalist—have found it necessary to pay heed to environmental influences, however, much they may have disagreed as to their consequences (Hippocrates, 1881).

Uses of Epidemiology

The epidemiological studies are very useful in the health studies to:

- Determine the frequency of a disease in the community
- Find distribution of the disease in the population with regards to qualitative attributes and quantitative variables as observed in the susceptible population.
- Identify the cause of a disease of unknown etiology
- Study the natural history of the disease

- Evaluate health intervention measures or activities
- Provide data base for health planners

This is measured by determining their effectiveness in reducing prevalence of the disease, and feasibility of the proposed measure being applied in the community on a large scale, keeping in view the financial constraints, manpower requirements and available time.

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9.5 MICROBIAL THEORY

Microbial theory, also known as Germ Theory in the field of medicine, states that certain diseases are caused by the intrusion of the body by organisms and microorganisms that are invisible to the naked eye. This development and acceptance of this theory are rooted in the work done by French chemist and microbiologist Louis Pasteur, Joseph Lister, an English surgeon, and the German physician Robert Koch.

Pasteur through his experiments showed the world that fermentation and putrefaction are caused by organisms in the air. The surgical practice was revolutionized by utilizing carbolic acid that helped prevent putrefaction in a compound fracture of bones, and this was done by Lister in 1860. Koch is credited with the identification of organisms that cause cholera and tuberculosis in the 1880s.

The germ or microbial theory evolved over a period of time. It was proposed in the mid-16th century and slowly gained recognition and popularity during the 17th through 19th centuries. Originally the theory was that diseases like cholera, Black Death, and chlamydia were spread by miasma which was believed to be a noxious form of bad air also referred to as night air.

The evolution of this theory was also possible due to the inputs received from Hindu medicine practitioners like Caraka, Susrata, and Vagbhata. Girolamo Fracastoro contended in 1546 that epidemic diseases were spread through direct or indirect contact or even without any contact at times.

A breakthrough of sorts happened in 1670 when Leeuwenhoek directly observed microorganisms. Taking Leeuwenhoek's discovery a step further, Nicolas Andry stated in 1700 that microorganisms were like worms that were responsible for causing various diseases. Richard Bradley added that these organisms were visible only through a microscope, this fact was discovered in 1720.

Between 1808 and 1813, Bassi became the first person to scientifically prove that microorganisms were the cause behind diseases. It was a chance discovery of the fact that diseases are contagious. It was noticed by a Hungarian obstetrician that women who delivered in a hospital showed a greater incidence of childbed fever than those who gave birth at home with the help of a midwife. It was found that those doctors who had helped during childbirth had actually completed autopsies and they were spreading the germs.

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During the period 1860 - 1864, a lot of experiments were carried out to finally come to the conclusion that a substance called boric acid could be used to arrest the spread of germs. The discoveries made during the 19th century by scientists like Pasteur, Koch, Lister, Iwanowski, Fleming, and numerous other scientists have helped to build the foundation for the scientific field and the microbial theory that we have before us today. Old theories about the spread of diseases have been discarded with the advent of more scientific and fact-based research.

The old germ theory, as it was called then, led medical practitioners to view all germs as bad and thus attempt to destroy them. The modified germ or microbial theory suggests that a balanced approach is more conducive towards understanding microbes. Some important facts are that -

- There are more microbial genomes present within our bodies than we have human cells (Harking).
- Humans are walking ecosystems (Dove)
- By exploring the relationship between microorganisms and humans, scientists are in a position to understand the boundaries between unhealthy and healthy individuals.

9.5.1 Process of Transmission

In the field of public health, biology, and medicine in general, the process of transmission of the disease is caused by the passing of a pathogen that causes communicable disease from an infected individual or group of individuals to another individual or group of individuals, regardless of that the fact that the other individual/s were previously infected or not.

The process of transmission is about the transmission of microorganisms directly from one individual to another. The means of transmission could be either one or more of the following:

(I) Direct
   (i) Person-to-person
   (ii) Droplet
(II) Indirect
   (i) Fecal-Oral
   (ii) Air-borne
(III) Vector
   (i) Fomites
   (ii) Insect Bite

(I) Direct Transmission

Direct Transmission means the disease is directly transmitted between one human or animal to another human or animal.

(i) **Person-to-person:** This can occur whenever an infected person touches or exchanges bodily fluids with another person. This can occur when a person kisses another person. Pregnant mothers may transmit the disease to an unborn child and blood transfusion from an infected person may also result in the transmission of diseases.

(ii) **Droplet:** Some diseases are spread through droplets suspended in the air after an infected person sneezes or coughs. These droplets touch other healthy people by landing on them and getting them infected. COVID-19 is a very potent example of this kind of disease transmission.

(II) Indirect Transmission

As the name suggests, indirect transmission occurs when a disease is passed from an infected person to another person even though both of them have not been in direct contact.

(i) **Fecal-Oral:** This kind of transmission occurs when an inordinately small amount, often microscopic, is transmitted from an infected person or animal to another person by mouth. This can happen when food/canteen workers use the washrooms and then don't wash their hands properly before cooking food and which is later consumed by others.

(ii) **Airborne:** As the name suggests, in this case, the germs are suspended in the air after an infected person coughs, sneezes, laughs, breathes, or even sprays water out of the mouth into the air. When another healthy person comes in contact with the suspended germs they get infected.

(III) Vector Transmission

Vector transmission occurs when another organism transmits a disease from person to person or from animal to person. This is known as a zoonotic (animal to person) transmission but differs from direct zoonosis where a vertebrate animal contracts a disease and transmits it directly to a person as is the case in rabies.

(i) **Fomites:** Fomites are inanimate objects which microbes latch on to and become vehicles for passing the disease from an infected person to another healthy person. Door-knobs, handrails, computer keyboards are common examples. When an infected person drinks water from a bottle and passes it on to other people to drink, then the infection is passed on to the others.

(ii) **Insect Bite:** Vector-borne diseases are more commonly transmitted through the bite of insects. Mosquitoes are the most common carriers of malaria and dengue parasites and they transmit it when they feed on an infected person and then again feed on a healthy person. The deadly plague which wiped out millions of people in Europe was transmitted by rats to humans through flea bites.

9.6 SOCIO-CULTURAL FACTORS BEARING ON HEALTH IN INDIA

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Medical practitioners and public health workers in India have been reporting that very often people do not utilize the medical and preventive facilities available to them. This is particularly true in case of people in rural areas. The health problems need special attention in context of rural people for two reasons. Firstly, rural people are less educated and secondly they have their own ideas and beliefs which are intimately connected with their socio-cultural habits and heath practices. It is important not only to study the socio-cultural dimensions of health, but also to examine the constraints of acceptance of modern health practices.

Every culture, irrespective of its simplicity and complexity, has its own beliefs and practices concerning diseases and evolves its own system of medicine in order to treat diseases in its own way, even though from the point of view of the western system they may appear to be irrational. It must be appreciated that more and more attention is now being given to the problems of rural health, as they represent a sizeable population of India. Since rural communities have varied socio-cultural traditions, economies and interaction, the concept of disease and nature of treatment are likely to be different.

If a health policy meant for rural people is to be formulated, it is important to study these traditional practices and their implications for modern medicine. Unfortunately, very little work has been done on the interaction between traditional and modern medical practices.

Data on health, the concept of disease and the nature of treatment are rather scanty and specific studies on this topic covering the different facets are practically non-existent. In this context, the following issues needed to be considered critically:

- belief related to disease and treatment
- role and position of traditional men in the society
- reasons for illness and treatment
- disease, treatment, and community
- interaction of traditional and modern system of medicine

It has been observed that the inference of supernatural powers is particularly strong in the case of main economic pursuits and in the context of health and disease. Thus, as the different agricultural or other economic activities are associated with rituals, similarly different deities and spirits are connected with various types of diseases. Thus, most of rural people have specific god and goddesses for their health and diseases, for calamities, for the cattle and so on. All these deities have their own respective departments and areas of influence, effect and control, as well as nature of action. Religious performances occupy small pox, mental illness, etc., which are believed to be associated with supernatural causes.

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The difficulty of defining the word 'disease' is implicit in its very structure. Disease may be defined as a condition in which a person's health is impaired and the functioning of any one or more organs is interrupted. It is the symptom, not the cause of ill health. A disease termed as pathological imbalance is caused due to convergence of environmental stimuli in time and space. It is the alteration of living tissues which jeopardizes survival in their environment and which results from an accidental collision between two or more forms of life, i.e. human beings and minute organisms like viruses. The organism will succeed in jeopardizing the health of a person only when both the external and environment (geographical and socio-cultural) in which it originates and internal environment (the human body) in which it grows offer favourable conditions for multiplication. Disease occurrence or non-occurrence is dependent upon a systematic integration of three factors: causative, preventive, and curative.

Lewis (1958) had noted that the advantage in learning about the indigenous beliefs and practices of a community is the insight they give into the world view of people since concept of disease causation is part of society's total world view, which is also reflected in other spheres such as agriculture, politics and inter-personal relations. Elwin (1955) lamented that there are various misconceptions associated with children's diseases, such as, cough, cold, blindness, measles, and diseases of pregnant women.

Swain (1993:34) states, "Traditional medicine has been defined as that whole, which includes a holistic knowledge and practice, oral or written functioned in diagnosis, preventive and curative aspects of illness and disease to promote well-being. Hence, the approach is holistic and a blend of physical, mental, social and spiritual well-being". Its use is global. Even in the face of sophisticated western system of medicine, it has thrived and is the only system available in the under-served areas of the country. Some of the methods practiced by them, even though they are harmful by our understanding, have been found to be positively beneficial and scientifically sound. They represent an autonomous system supported by the community, while the allopathic drugs are not available or have been found to be very expensive. Among the rural people, there exists a group of specialists, priests, magicians or medicine men whose services are sought after depending on the cause of illness. Thus, the priests worship the deities and when epidemics or diseases occur in the villages, he offers a sacrifice at the sacred place. He is mainly entrusted with the benevolent deities. Magicians, often through their performances, control the malevolent deities. Generally, these specialists and the rural people have a common faith in the techniques used, as they quite often share the same cultural traditions. The dependence on and the confidence in traditional medicine men or magicians are often responsible for the non-acceptance of modern medicine. The traditional approach establishes faith and assurance in the patients while modern medicine lacks this. Carstairs (1955), a medical psychiatrist and anthropologist, pointed out that differences between the points of view of physicians and the village folk with regard to the theory of etiology, techniques of curing and

conceptions of roles of physicians resulted in misunderstanding between himself, a physician, and the client.

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Marriott (1955) has shown how the contacts and conflicts between the roles assumed by the indigenous and western medical practitioners resulted in obstacles to the acceptability of western medicine.

Health and treatment also reflect the social solidarity of the community. For example, illness and the consequent treatment may be taken at the community level. In case of some specific diseases, not only the diseased person and his/her family, but the total village community is affected. All the other families are expected to observe certain taboos or norms and food habits. The non-observance of such practice often calls for action by the village council. One cannot deny the impact of the psychological support in the context of treatment and cure, which is common among rural people. In most of the rural communities, there are a number of folklores related to health. Certain practices are suggested to avoid illness or disease, while some others are prescribed for better health. These should not be ignored as mere folk-beliefs, but they need careful attention. There are different folklores to avoid illness, during illness, regarding food and so on. Documentation of such folklores available in different socio-cultural system may be very rewarding and may provide the model for appropriate health and sanitary practices in a given ecosystem.

The interaction of traditional and modern system of medicine is an important aspect of the studies particularly in the context of rural communities. A few studies conducted on the issue have yielded some answers to the question. Why are some aspects of modern medicine accepted while others are rejected? But, the validity can only be established when we have a large number of studies. Till date research on this problem is somewhat inadequate, though there is great need to understand the socioeconomic and cultural dimensions of health and illness. Any policy formulation on health for rural communities should take these aspects seriously.

Is the socio-cultural dimension of health a myth or reality? In a sense it is a myth, in another context it is reality. Thus, if people worship a deity for cure, automatically it is assured that they are all superstitious and would not accept the so called modern health practices, but perhaps it is forgotten that the same thing is also performed in the cities of India and in the Churches of Europe. The question of rationality cannot be judged or examined in isolation, without examining the ecosystem, health facilities available and socioeconomic conditions. Again, the mere presence of health depends on whether proper and adequate facilities were not available. However, socio-cultural tradition does play an important role in the context of health and treatment. The common beliefs, customs and practices connected with the treatment of diseases. Again, when a person goes to the traditional medicine men, she/he gets something more beyond physical health. It is the socio-psychological reinforcement, which one gets from the modern medical practitioners. The social reinforcement based on the understanding of traditional beliefs and practices is often lacking and may be one of the reasons for making a medical practitioner unsuccessful in rural areas. In fact, a number of scholars have

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pointed out that if scientific medicine is to be carried to total communities, it is necessary for medical practitioners to have knowledge about the culture of the concerned rural community. A medical practice having the roots in alien culture has enhanced conflict between different cultural values. Besides socio-cultural reasons, the inadequate nature of facilities in many rural areas, and lack of attention towards the patient has brought a distrust in rural people toward modern medicine.

There are number of social scientists particularly who deal with the health studies in the domain of culture of rural population, analyze the health beliefs and practices but do not pay much attention to the causes or forces which are responsible for uprooting the health culture.

Sociology of Illness

Disease, as defined by doctors, is an abnormal condition affecting the body of an organism and is based upon the observation of biological pathology. The conception of disease is 'objective', 'scientific' and based on the biomedical model of pathology which is the basis of modern medical thought. In contrast to the 'objective view of disease, the concept of illness refers to the person's subjective experience of ill health. It goes beyond the biological and physical consequences of disease, affecting the person's subjective well-being and their social functioning. Illness is recognized by departures from the person's normal state of being and by altered feelings which may be diffused.

To be ill, then, is not simply to be in a physically altered state, but also to be in a socially altered condition which is normally disruptive of everyday life and is undesired. Illness is both personal and social. The individuals who feel ill are likely to talk to others in their attempts to make sense of their physical symptoms and feelings of 'disease' and departure from normal functioning. While they may draw upon biomedical ideas and knowledge to make sense of their illness, people also use other ideas which are current in their social groups both to make sense of their illness and to decide what action, if any, should be taken. For example, ideas of what constitutes 'flu', how to recognize it, and how to treat it (feed a cold, starve a fever). Such 'lay theories' of illness may be complex and detailed, and provide explanations which link the experiences of illness to the personal and social circumstances of the ill person in ways which may be more consistent and believable to them than professional medical explanations.

Check Your Progress

4. List three uses of epidemiology.
5. What does the microbial theory state?
6. How is the transmission of disease caused?
7. What are fomites?
8. What is a disease termed as pathological imbalance caused by?

9.7 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

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1. The natural history of disease refers to the uninterrupted progression in an individual of the biological development of disease from the moment that it is initiated by exposure to the casual agents.'
2. Incubation period depends on:
   - Portal of entrance into the host
   - The capability of multiplication
   - Quantity of agent
   - Amount of antibody in the host
3. An exposure to the same disease can have varied manifestations in different individuals; this is known as disease spectrum.
4. The three uses of epidemiology are:
   - Study the natural history of the disease
   - Evaluate health intervention measures or activities
   - Provide data base for health planners
5. Microbial theory, also known as Germ Theory in the field of medicine, states that certain diseases are caused by the intrusion of the body by organisms and microorganisms that are invisible to the naked eye.
6. Transmission of the disease is caused by the passing of a pathogen that causes communicable disease from an infected individual or group of individuals to another individual or group of individuals, regardless of that the fact that the other individual/s were previously infected or not.
7. Fomites are inanimate objects which microbes latch on to and become vehicles for passing the disease from an infected person to another healthy person. Door-knobs, handrails, computer keyboards are common examples.
8. A disease termed as pathological imbalance is caused due to convergence of environmental stimuli in time and space. It is the alteration of living tissues which jeopardizes survival in their environment and which results from an accidental collision between two or more forms of life, i.e. human beings and minute organisms like viruses.

9.8 SUMMARY

- Individuals living a healthy life, free from any disease is an ideal concept, in actuality, they are likely to get exposed to various agents, some of which can be disease causing. All of this collectively increases susceptibility to disease and burden of the disease.

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- The concept of epidemiological studies of natural history states that the studies can be carried out only with the consent of the individuals. Studies are allowed when there was no treatment modality applied for that condition.
- When incubation span ranges few days, few weeks, and sometimes months, the diseases are called Early Onset Diseases**.** An acute disease can have irreversible (chronic) effects.
- In non-communicable disease, the pre-symptomatic disease stage includes the latency period, which can be defined as the period from disease initiation to disease detection. In addition, the stage of susceptibility also includes the subclinical disease that is a disease which is fully developed but produces no overt signs or symptoms in the host.
- The final stage of natural history of disease is characterized by a convalescent period or a residual disability. In the case of convalescence, there is a period following completion of clinical disease, during which the individual has not yet returned to his or her former level of health.
- The etiology of a disease refers to its cause or its origin. Etymologically, etiology is also the name for the study of the causes of diseases. It may also refer to the study of the cause of things in other fields like sociology.
- Dahlgren and Whitehead's (1991) have significantly contributed to illustrating the wider determinants of health. Their study effectively represents how various individual, social, economic, and cultural factors have a direct bearing on the inequalities in health and illness.
- Infectious diseases are common among early age groups, and degenerative diseases among older age-groups, while some like tuberculosis and cancer are common among adolescents and adults.
- Registration of sickness is generally limited to notifiable infectious diseases, as it is compulsory, for early information to public health departments, taking necessary action.
- The germ or microbial theory evolved over a period of time. It was proposed in the mid-16th century and slowly gained recognition and popularity during the 17th through 19th centuries. Originally the theory was that diseases like cholera, Black Death, and chlamydia were spread by miasma which was believed to be a noxious form of bad air also referred to as night air.
- Between 1808 and 1813, Bassi became the first person to scientifically prove that microorganisms were the cause behind diseases. It was a chance discovery of the fact that diseases are contagious.
- The old germ theory, as it was called then, led medical practitioners to view all germs as bad and thus attempt to destroy them. The modified germ or microbial theory suggests that a balanced approach is more conducive towards understanding microbes.

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- In the field of public health, biology, and medicine in general, the process of transmission of the disease is caused by the passing of a pathogen that causes communicable disease from an infected individual or group of individuals to another individual or group of individuals, regardless of that the fact that the other individual/s were previously infected or not.
- Some diseases are spread through droplets suspended in the air after an infected person sneezes or coughs. These droplets touch other healthy people by landing on them and getting them infected.
- Every culture, irrespective of its simplicity and complexity, has its own beliefs and practices concerning diseases and evolves its own system of medicine in order to treat diseases in its own way, even though from the point of view of the western system they may appear to be irrational.
- Swain (1993:34) states, "Traditional medicine has been defined as that whole, which includes a holistic knowledge and practice, oral or written functioned in diagnosis, preventive and curative aspects of illness and disease to promote well-being. Hence, the approach is holistic and a blend of physical, mental, social and spiritual well-being".

9.9 KEY WORDS

- **Putrefaction**: It is the decay of the organic matter by the action of microorganisms resulting in the production of a foul smell. It occurs between 10 to 20 days of the death of an organism.
- **Spectrum of Disease:** It refers to the range of manifestations and severities of illness associated with a given disease, illnesse, or injury.
- **Ecology:** It is a branch of biology concerning the spatial and temporal patterns of the distribution and abundance of organisms, including the causes and consequences.
- **Transmission:** It is the passing of a pathogen causing communicable disease from an infected host individual or group to a particular individual or group, regardless of whether the other individual was previously infected.
- **Traditional Medicine:** It comprises medical aspects of traditional knowledge that developed over generations within various societies before the era of modern medicine.
- **Pathogen:** It is a biological agent that causes disease or illness to its host.

9.10 SELF ASSESSMENT QUESTIONS AND EXERCISES

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Short-Answer Questions

1. Why is information about the natural history of many diseases not known?
2. How do case-mortality rates vary? Give examples.
3. Where is the earliest recognition of the role of the environment found in literature?
4. List some important facts of the modified microbial theory.
5. Write a short note on vector transmission.
6. Why do health problems need special attention in context of rural people?
7. List the issues that need to be considered with regard to socio-economic factors affecting health in India.

Long-Answer Questions

1. Discuss the ways in which natural history and population pattern of a disease are interconnected.
2. Elaborate upon the evolution of microbial theory over a period of time.
3. Examine the means of direct and indirect transmission.
4. Explain the traditional medicine approach.

9.11 FURTHER READINGS

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UNIT 10 HOSPITAL AND HEALTH PROFESSION IN SOCIETY

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Structure

10.0 INTRODUCTION

A hospital is an important organization that provides a number of facilities related to health such as treatment, check-ups, surgeries, medications and so on. It follows an organized manner of functioning and operates systematically based on a set of principles aimed at providing the best services to patients and their families. Several types of hospitals exist based on their specialty. It is an important institution that offers health care services to people for the maintenance of health and quality of life. In this unit, the functions and organization of hospitals have been discussed.

10.1 OBJECTIVES

After going through this unit, you will be able to:

- Analyze hospital as a social institution and organization
- Discuss the structure and functions of a hospital
- Describe the organization of modern Indian hospitals
- Examine the cost of hospitalization and medical social services provided in a hospital

10.2 HOSPITAL AS A SOCIAL INSTITUTION

Large social groups that are formed to achieve specific goals have come to dominate the social structure of societies only in modern times. In simpler societies, health care, education, support for the elderly, and the like were provided by the family

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or by other members of the community. But in industrial nations, life is more complicated and seems to require an ever-growing array of organizations. For most of us, life begins in an organization—a hospital. The doctors, nurses, anaesthetists, orderlies, and others work together to perform the task of providing healthcare. After leaving the hospital, one passes through other organizations—nursery school, elementary school, high school—each with its own structure and routines. When one finishes school one does not escape from organizations. As an adult, one is likely to be employed by an organization. One may come across others as well—the Internal Revenue Service, the armed forces, the police, banks, stores, and so on. After one retires, the social security system, health-care agencies, hospitals and perhaps nursing homes re-enter our lives. Even in death, organizations are close at hand—funeral homes, banks, law firms, tax agencies, and the courts in which our heirs must settle our affairs.

Many medical sociologists focus more narrowly on organizations in the endeavour to understand the implications of organizational structure and dynamics in health services setting. Work done in the field of medical sociology during the 1960s and the 1970s explored various dimensions of healthcare organizations. These classical works emphasized and described in detail advances in technology and economic opportunities in the healthcare sector and with the epidemiology shift from acute to more chronic and long-term health conditions, the types and variety of healthcare organizations, which saw a dramatic expansion from 1960s onwards. These early studies made a major contribution to our fundamental understanding of emerging health systems. They also highlighted innumerable organizational challenges in delivery of health services, including the "depersonalization and devaluing of patients (Coe, 1978); the inter-personal dynamics between doctors and patients (Freidson, 1970); the power relationships and conflicts among health professional groups (Gross, 1963); and the tendency toward bureaucratic medical decision making treatment (Freidson, 1970)". In contemporary times, medical sociologists have examined crucial organizational changes that have implications for the method and type of care delivery, as well as effectiveness of care for various social groups. Sociologists have also examined organizational features, such as leadership centralization, differentiation hierarchy and size, factors which can influence outcome, the extent and nature of adoption of effective medical technologies in hospitals and health systems (Flood, 1994; Scott, 1990).

Organizing is the process of grouping the various activities into workable units and connecting them through authority, control and co-ordination so as to perform identified jobs for achieving organization objectives. Every organization has a structure called 'Organogram' and the structure varies according to function. Each organization has distinct structure, objective and function, and therefore differs from all others.

Organization structure that forms the basic skeleton of the organization:

- helps to identify inconsistencies and complexities in the organization structure

- helps to identify major line of decision making authority
- helps indicate to the employees their position, status, and role in the organization

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Each organization therefore has its own peculiarity to ensure its effectiveness. A hospital is a similar social organization with a "rational combination of the activities of a number of persons with different level of knowledge and skills for achieving a common goal of patient care through a hierarchy of authority and responsibility".

Total Institutions

Voluntary associations are formed to promote some common interest of the members. **Total institutions**, on the other hand, are formed to promote the good of society as defined by state, religious, or other agencies. Examples of total institutions are jails, military academies, etc. Members of the total institutions are isolated from the society. Often they are supervised by custodians. The custodians have authority over a wide range of behaviour, including the feeding, housing, and even personal care of the inmates. Erving Goffman (1961), who coined the term total institution, has divided these organizations into several classes: (1) hospitals, homes and sanatoriums designed to house people who are thought to be unable to care for themselves (the blind, the aged, the poor, the ill); (2) jails (and concentration camps), which are designed to house people who are thought to be dangerous to the community; (3) military barracks, ships, boarding schools, work camps, and other institutions designed to perform specific tasks; and (4) monasteries, convents, and other retreats in which people remove themselves from society, usually for religious reasons.

Hospital as a Social System

In a social system, the elements are human beings or social groups interacting with each other. When interactions are directed towards the fulfillment of certain goals, they are patterned and there exists an ordered relationship, they interact with each other for facilitating their counterparts, and there is a motivational force which operates along with the aforesaid factors the social structure may be termed as a social system. The various sub-systems of a social system may also be seen as a social system. For studying any social system, the boundaries of the social system interact with several other social systems and are greatly affected by these other systems and thus there is a systemic linkage.

Sorokin (1951) views social system as an organization that possesses a set of enforced, obligatory norms defining in details the rights, duties, social positions and functions, roles and proper behaviour of each and all its members towards one another, outsiders and the world at large; a set of prohibited actions-relations sanctioned by punishment, and a set of recommended non-obligatory norms of conduct. According to him, "the social system is composed of the patterned interaction of members. It is constituted of the interaction of plurality of individual actors whose relations to each other are mutually oriented through the definition

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and mediation of pattern of structured and shared symbols and expectations." There needs to be an organized social structure, the functioning of which will form the social system. There can be various structural components of the social system. Parsons (1959), states, "a social system may be analyzed on four levels of generality so far as its units are concerned:

1. Individuals in roles are organized to form what we call collectivities i.e. individuals are considered as a whole group.
2. Both roles and collectivities, however, are subject to ordering and control, by
3. Norms which are differentiated according to functions of these units and to their situations, and by
4. Values which define the desirable kind of system of relation.

Hospital as an Organization

Hospitals are typically large institutions with a diversity of activities and personnel within them. While the hospital is chiefly a setting for medical practice, it has, by virtue of being an organization, many characteristics of its own. Hospitals have been analyzed from a variety of perspectives, but sociological work has focused on the hospital as a social organization, drawing on general sociological work on organizations, and on the experiences of patients and staff (Morgan et al., 1985)

As other work organizations in modern society, the hospital displays many of the attributes of bureaucracy that were delineated by Max Weber (Gerth and Mills 1946). It is a rational organization with an elaborate, systematic division of labour and a high degree of specialization of structure according to a principle of hierarchy, and governed by impersonal roles and norms.

The hospital, however, differs from the Weberian paradigm in several aspects which causes conflict and further limits the efficiency of the hospital's performance as an organization. One of these aspects is attributed to the fact that the functioning and governance of the hospital is premised on a number of parallel lines of professional authority (Perrow, 1965). Each of the numerous professional groups in the hospitals has its own department and set of services with varying amount and styles of control over its specialized work. There are also paramedical professionals and call professionals under its supervision. These include physicians, nurses, technicians, social workers, clerks just to name a few. An organization with weak internal structures and high complexity is hypothesized to be more informal than bureaucratic, rely more on mutual negotiations than on administrative fiats to coordinate and control action and have a more pluralistic symbolic culture (March and Olsen, 1979).

Hospitals have changed more dramatically than any other kind of corporation, from small philanthropic endeavours to the centre of complex health services. They have grown in size, complexity, and technology and are even considered as

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a big business (Rakich and Darr, 1978). However, hospitals are different from other complex organization in terms of their nature of work particularly in terms of human relations. Following are the features of hospital organizations:

- The first goal of the hospital organization is the welfare of the patient whereas in others it might be corporate profit. Since health is the right of every individual, therefore, the profit making motive of the organization in case of hospital is minimal. Public interests supersede profit-making. Hospital owes its responsibility towards society. In the actual situation, there is a diversity of goals and aims of different personnel and sub-systems within hospitals' organization. Sometimes, there are situations when patient care, research activities are contradictory and it gives rise to conflicting situations in the hospital organization.
- Hospital organizations are often called bureaucratic organizations where there is rank and file system. The hospital organization has formal and written rules and regularities and there are formal procedures to control its members. For example, each hospital displays the duty chart of doctors, nurses and other personnel. It is mandatory for each patient to give his/her consent before an operation and medication cannot be released simply on the will of the patients. Paradoxically, the hospital is in continuous operation (Fox, 1989). Automatically, this requires the high cost which in turn, hampers the efficiency of bureaucratic system.
- The hospital is a 'people-centric' organization where the goals are linked to individuals working in the organization, therefore, the technology cannot replace the people who are working. The working force of the hospital requires integrity, skills, motivations and behaviours of its members to achieve the goal of the hospital for patients' care. Despite the drastic change in modern complex organizations and growth of technological innovations in medical practice, the working force of people of hospital cannot be replaced by machines. At the same time, hospital organization has all sorts of working people ranging from cleaner/sweeper to the highly specialized surgeon. To coordinate the work of all these personnel, coordination is required and that is termed as hospital management.
- Hospital organization does not have a single line of authority. Many studies have investigated the power structure of hospitals and found that there are 'dual lines of authority' or 'power in triad' (Mishler et al., 1981; Taylor, 1975). Administrators are responsible for managing the administrative problems, physicians for patient care, researchers are for research in their respective area, etc. Each group of personnel has its own norms, communication network, and hierarchies. However, professionals, like doctors, possess a certain degree of independence and autonomy in their work. Besides that there are situations of conflict between senior and junior doctors, between matron and nurses, etc. Theoretically, this arrangement permits a sharing of power among the

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groups, but one of them may dominate the organization depending on particular problems or tasks that the hospital must emphasize at any given time (Perrow, 1986).

Thus, to conclude, that the hospital organization has generic conflicts, i.e. conflicts which are characteristic to hospitals. These conflicts sometimes help in solving the potential problems in advance. Since hospitals deal with the problem of life and death situations, therefore, the hospital organization cannot afford to allow any sort of negligence in dealing with the patients. Thus, in all hospitals organization is always under the pressure of physical and psychological stress. Recently, there is a growth of corporate culture in the hospital organization.

Although corporate culture is a Western concept, but more and more corporate hospitals are developing in other parts of the world. It is necessary to understand the corporate culture. Corporate culture is diverse, but it is defined as "patterns of belief or shared meaning, fragmented or integrated, and supported by various operating norms and rituals which exert a decisive influence on the overall ability of the organization to deal with the challenges that it faces (Morgan, 1986)". In the previous approaches of hospital organizations, the normative element, which includes customs, and cultures are more important. However, with the growth of corporate sector, the hospital organizations are also affected by corporate culture.

10.2.1 Structure and Functions of a Hospital

For the functioning of a hospital organization, a few functional pre-requisites are essential. Parsons' social system model deals with four functional problems: (1) Adaptation, (2) Goal attainment, (3) Pattern maintenance and tension management, (4) Integration.

Loomis (1960) described and analyzed social system in terms of nine elements: (1) Belief, knowledge, (2) Sentiments, (3) End goal or objective, (4) Norms, (5) Status and role, (6) Rank, (7) Power, (8) Sanction, and (9) Facility. He has summarized his views in a Personality Articulated Structural Model. He, like Parsons, prescribes social conditions for action. Georgopoulos and Matejko (1967) have studied complex social system in terms of six problem areas:

1. Organizational goals, member goals and their attainment
2. Availability and allocation of organizational resources
3. Organizational coordination
4. Social interaction
5. Intra-organizational strains and conflicts resolution
6. Organizational adaptation

The major functional dimensions of hospital organization or social system are discussed below:

- **Goal attainment:** The goal of a hospital is to provide medical care. It includes doctor's role performance, healthcare, patient satisfaction, and

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patient care. Doctor's role performance helps in providing proper medical care and these results in higher patient satisfaction.

- **Tension management:** The process of tension-management is important for internal stability of the hospitals. Tension management includes variables like criticism, harassment, appreciation, and trust. It could be seen that avoidance of criticism and harassment were significantly correlated with appreciation and trust in the work-groups.
- **Professional growth:** In case of professionals, learning is very important. Professional learning, use of abilities, work-motive and management of problems constitute the professional growth of the doctors.
- **Member goals:** The goals of hospital functionaries appear to be different from organizational goals. The member-goals are mainly individualistic and related to pay, promotions, working hours and benefits.
- **Work environment:** The work is determined by reputation of the hospital, working hours, liking for work and work group, guidance, etc. If the hospital performs well in these variables then that hospital is rated good.
- **Adaptation:** The adaptation factor is important for adjusting with external environment. The variables noticed are: use of improved work methods, fulfillment of community needs, clarity of rules, and use of abilities.
- **Assistance:** The role performance of paramedical staff and auxiliary staff plays an important part in functioning of the hospital social system. The variables which cluster in this factor specially relate to the role for sweepers and nursing professionals, work according to rules and management of problems. In professional organizations assistance provided by subordinate staff seems to play an important role.
- **Involvement:** This factor related to the involvement of hospital employees in the hospital social system. The clustering of items related to work encouragement, desire to continue working in the same hospital, help by superiors and avoidance of conflict.
- **Coordination and integration:** The variables which have high factor loadings are: avoidance of conflicts, inter-departmental coordination, and timing of everyday activities, and nurses' role performance.
- **Values:** Values are related with values of the hospital functionaries. The values governing superior-subordinate interaction, trust, directions and appreciations have high correlation with good hospital.

Functions of a hospital as a unit

Hospitals are among the most complex organizations in modern society, characterized by extremely fine division of labour and an exquisite repertory or

collection of technical skill. The major hospitals embrace multiple goals, chiefly patient care, teaching, and research. It is at once a hotel, a treatment centre, a laboratory, a university. Because the institution's work is so specialized, staffed by a variety of professional and technical personnel, there are very important problems of co-ordination and authority. Paramount in the social structure are relationships between patients and hospital staff and among staff members. The patient, both client and product of the organization, enters a therapeutic situation in which his style is largely passive. He/she encounters the physician—like himself, a 'guest' of the hospital—and the nurse, who is the full-time symbol of the organization's atmosphere. The physician is undergoing a shift from his/her older charismatic role toward a more nearly bureaucratic niche in the hospital. Staff relationships are distinguished by unclear patterns of authority and intense competition for spheres of competence and prestige. The physician is implicated as the professional least amenable to hierarchical control and the leading figure in skill and status. Although the hospital illustrates vital, unresolved issues in the organization of work, it flourishes under the impetus of professional zeal and patients' needs.

Organization of modern Indian hospitals

Hospitals in India are replicas of the Western hospitals in almost all aspects. The misappropriate grafting of hospitals in India has eventually given rise to many ambiguities in the medical as well as in the socio-cultural fields. The hospital as an institution in India is the apex of modern medical system which is subserved by dispensaries, primary health centres and sub-centres all over the country. Hospitals in India are a welcome diffusion for a handful of urban patients and for many rural patients. A patient who is not accustomed to undergo a sick role and that too in a totally new atmosphere, cannot be the real beneficiary of the hospital. This is the case at least in most of the cases. The bureaucratic set up of the hospital has been spoiled by preferential treatment. The hospitals in India are running with below average staff, doctors and other medical requirements. In other words, the managerial administrative atmosphere is 'sick'. The hospitals are not taking other smaller medical institutions as complementary to the comprehensive healthcare process; rather these are expected to act as subservient to the hospital.

10.3 COST OF HOSPITALIZATION

Health care costs, especially hospitalization costs are increasing with every passing day. In the context of health care costs, institutional care is a growing component. However, in most developing countries, there is inadequate knowledge regarding the costs of different medical services. In recent years, it has been noticed that there is greater utilization of hospital services in India; this is due to the rising incomes and, to some extent, is attributable to the government insurance programs that cover inpatient services. Despite this, it cannot be said that the unit cost information from Indian hospitals is adequately available.

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The India Fit report from GOQii states that one in every three people in India, above the age of 30, suffer from lifestyle-related diseases. These range from diabetes to cardiac problems and high cholesterol to even cancer. It is often that these get aggravated due to poor diet and lifestyle choices. Battling such diseases usually attracts huge expenses and can cause serious monetary hardships. Moreover, the financial impact is not limited to the cost of hospitalization alone, it extends to the pre and post-hospitalization stages and beyond. Several diagnostic tests, scans, and OPD expenses are routine expenses incurred in the pre-hospitalization stage.

The Economic Times states that nowadays 3 out of 10 patients opt for treatment in tier-2 and tier-3 cities. This provides healthcare providers with the opportunity to set up medical centers in non-metro cities in order to cater to the rising demand for decent healthcare facilities. The hospitals have realized that a large part of India's growing income lies in these markets. Not everyone is financially well off to be able to afford treatment in metro cities, thus medical care in these non-metro cities needs to be far more affordable.

In research undertaken in 2013, a detailed study of 5 hospitals in India on the parameters of estimated operating cost, cost per outpatient visit, cost per surgery, cost per emergency room visit, and cost per inpatient stay was done. It was found that the significant cost components varied on the lines of material costs, human resources, and capital costs based on the type of hospital. The outpatient cost varied widely, from ₹94 in district government hospitals to ₹2213 in private hospitals. The inpatient cost ranged from ₹ 345 in private teaching hospitals, to ₹ 394 in district hospitals, ₹ 614 in the tertiary care hospitals, ₹ 1959 in the charitable hospitals and ₹6996 in private hospitals. The study was conducted on a very minimal scale but it adequately demonstrated that detailed costing of Indian hospital; operations are feasible and essential. Given the fact that there is significant variation in the country's hospital types, a more detailed and in-depth study can be undertaken to refine the hospital costing of the different hospital types across India. The results can be used for the formulation of policies and also act as a benchmark for government-sponsored insurance schemes.

In this context, a survey conducted by the National Statistical Office (NSO) in India revealed that an average household incurred seven times more medical expenditure during hospitalization excluding childbirth while being treated in non-government hospitals.

The comparative rates in government hospitals in the rural and the urban areas were pegged at ₹4290 and ₹4837 respectively. The average works out to be around ₹4452. As against this, in private hospitals, the expenditure is a whopping ₹31845 on average; in rural areas, it is ₹27347 while it is ₹ 38822 in urban areas. These figures are for the period between July 2017 and June 2018 as declared by NSO collated from the National Sample Survey (NSS) on Household Social Consumption related to health.

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Other statistics gathered as a result of the survey state that on average the medical expenditure per hospitalization is approximately ₹ 26475 in urban areas as against ₹ 16676 in rural areas.

These surveys conducted periodically, covered approximately 113 lakh households in the latest survey. Similar surveys were carried out in 1995-96, 2004, and 2014. These facts and figures provide a glimpse of the manner in which the cost of hospitalization is projected in India.

Private Hospitals account for about 55 percent of the in-patient hospitalizations (excluding childbirth). It is 42 percent in the government/public hospitals and 2.7 percent in the charitable trust and NGO-run hospitals.

As regards childbirth, the average expenditure per government hospital was about ₹2404 and ₹3106 in rural and urban areas respectively. In private hospitals, these figures went up to ₹20788 and ₹29105 in rural and urban areas respectively.

10.4 MEDICAL SOCIAL SERVICE IN A HOSPITAL

The primary job of the Medical social workers is to help the patients and their family members cope with the emotional and social fallout of the illness and its treatment. These social workers also provide the basic support to the patients and their families by educating them about the community resources that are available, the entitlements, and the sundry health insurance coverages that can help to take care of the patients in a more efficient manner. They often lead support group discussions or extend assistance by providing individual counseling.

Broadly, Medical Social Work is an off-shoot or sub-discipline of social work. According to the National Association of Social Workers, USA, social workers in the field of medicine play a very important role in the non-medical aspects of patient care. They take the responsibility of guiding the patients and their families to navigate the medical system, at the same time they direct their efforts to assess and monitor the patients' and their family members' emotional and mental health. They also act as facilitators and convey the patient's needs and concerns to the larger medical team.

In a hospital setup, the role and scope of the medical social service provider will depend on certain factors. For effective services to be provided, the following points individually and collectively need to be considered:

I. **The Hospital:** How efficiently does the hospital operate? Are there trained people who interact with the patients and note down their needs and assess their capabilities and status, or are they being looked after by untrained people who are uninitiated to the requirements of medical social service?

II. **The School of Nursing:** Does the school provide its student nurses with the opportunity to train in the area of social and public health

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work? There is an increasing need to fill positions in the field of medical social service in hospitals for nurses with proper social and public health training.

III. The Patient: How much importance does the hospital attach to the family problems faced by the patient? Do they give a thought to the fact as to whether there is someone to take care of young kids and home when the mother is sick and confined to the bed in the hospital? Is there any scope to provide support to weak patients after their discharge? Does the responsibility of the hospital end with the discharge of the patient?

IV. Community Resources: Do community resources exist in the true sense of the term? If they exist then are they efficient and do they care for patients needing outside nursing care? Do they offer with or all of the following-local facilities for convalescence, homes for children, homes for adults?

For the effective use of medical social service in hospitals, the answers to the above questions can be very relevant. The field of medical social service can also be very specialized. It is possible that a set of social workers acts dedicatedly towards serving only patients awaiting transplants or serving only babies receiving neonatal care. The hospitals may also employ social workers who serve a larger variety of clients with ongoing medical issues.

Check Your Progress

1. What did the classical works in the field of medical sociology emphasize?
2. How does Sorokin view 'social system'?
3. What does the working force of the hospital require**?**
4. Which four functional problems does Parson's social system model deal with?
5. What is the greater utilization of hospital services in India attributable to?

10.5 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The classical works emphasized and described in detail advances in technology and economic opportunities in the healthcare sector and with the epidemiology shift from acute to more chronic and long-term health conditions and the types and variety of healthcare organizations.
2. Sorokin (1951) views social system as an organization that possesses a set of enforced, obligatory norms defining in details the rights, duties, social positions and functions, roles and proper behaviour of each and all its

members towards one another, outsiders and the world at large; a set of prohibited actions-relations sanctioned by punishment, and a set of recommended non-obligatory norms of conduct.

3. The working force of the hospital requires integrity, skills, motivations and behaviours of its members to achieve the goal of the hospital for patients' care.
4. Parsons' social system model deals with four functional problems: (1) Adaptation, (2) Goal attainment, (3) Pattern maintenance and tension management, (4) Integration.
5. In recent years, it has been noticed that there is greater utilization of hospital services in India; this is due to the rising incomes and, to some extent, is attributable to the government insurance programs that cover inpatient services.

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10.6 SUMMARY

- In simpler societies health care, education, support for the elderly, and the like were provided by the family or by other members of the community. But in industrial nations, life is more complicated and seems to require an ever-growing array of organizations.
- Many medical sociologists focus more narrowly on organizations in the endeavour to understand the implications of organizational structure and dynamics in health services setting. Work done in the field of medical sociology during the 1960s and the 1970s explored various dimensions of healthcare organizations.
- Organizing is the process of grouping the various activities into workable units and connecting them through authority, control and co-ordination so as to perform identified jobs for achieving organization objectives.
- Voluntary associations are formed to promote some common interest of the members. Total institutions, on the other hand, are formed to promote the good of society as defined by state, religious, or other agencies. Examples of total institutions are jails, military academies, etc.
- When interactions are directed towards the fulfillment of certain goals, they are patterned and there exists an ordered relationship, they interact with each other for facilitating their counterparts, and there is a motivational force which along with the aforesaid factors operating the social structure may be termed as a social system.
- The first goal of the hospital organization is the welfare of the patient whereas in others it might be corporate profit. Since health is the right of every individual, therefore, the profit making motive of the organization in case of hospital is minimal. Public interests supersede profit-making.

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- The hospital is a 'people-centric' organization where the goals are linked to individuals working in the organization, therefore, the technology cannot replace the people who are working.
- Hospital organization does not have a single line of authority. Many studies have investigated the power structure of hospitals and found that there are 'dual lines of authority' or 'power in triad'
- For the functioning of a hospital organization, a few functional pre-requisites are essential. Parsons' social system model deals with four functional problems: (1) Adaptation, (2) Goal attainment, (3) Pattern maintenance and tension management, (4) Integration.
- Hospitals are among the most complex organizations in modern society, characterized by extremely fine division of labour and an exquisite repertory or collection of technical skill. The major hospitals embrace multiple goals, chiefly patient care, teaching, and research.
- The India Fit report from GOQii states that one in every three people in India, above the age of 30, suffer from lifestyle-related diseases. These range from diabetes to cardiac problems and high cholesterol to even cancer.
- Private Hospitals account for about 55 percent of the in-patient hospitalizations (excluding childbirth). It is 42 percent in the government/ public hospitals and 2.7 percent in the charitable trust and NGO-run hospitals.
- Broadly, Medical Social Work is an off-shoot or sub-discipline of social work. According to the National Association of Social Workers, USA, social workers in the field of medicine play a very important role in the non-medical aspects of patient care.

10.7 KEY WORDS

- **Organogram**: It is a diagram that shows the structure of an organization and the relationships and relative ranks of its parts and positions/jobs.
- **Total Institution:** It is a place of work and residence where a great number of similarly situated people, cut off from the wider community for a considerable time, together lead an enclosed, formally administered round of life.
- **Paramedical Staff:** It refers to personnel including all types of professions related to medicine, e.g., personnel in the fields of nursing, midwifery, sanitation, dental hygiene, pharmacy, physiotherapy, laboratory medicine, therapeutic exercise, etc.

10.8 SELF ASSESSMENT QUESTIONS AND EXERCISES

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Short-Answer Questions

1. What are some organizational features examined by sociologists?
2. What does an organization structure that forms the basic skeleton of the organization help to do?
3. List the four levels of generality on which a social system is analyzed.
4. State Loomis' nine elements in terms of which he describes a social system.
5. What services do social workers provide to patients and their families?

Long-Answer Questions

1. Discuss the contributions made by the early studies in medical sociology.
2. Elaborate upon Erving Goffman's classification of total institutions.
3. Explain two features of hospital organizations.
4. Evaluate the major functional dimensions of hospital organization or social system.

10.9 FURTHER READINGS

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BLOCK - IV
PROFESSIONALIZATION OF HEALTH PERSONNEL AND MANAGEMENT HEALTH CARE SERVICES

UNIT 11 PROFESSIONALIZATION OF HEALTH PERSONNEL

Structure

11.0 INTRODUCTION

Professionalization of health personnel helps to ensure patient safety and improvement in medical services. Professionalism is an essential attribute for every medical personnel and they need to be in possession of the right attitude and their behaviour towards their patients and their family members should be disciplined and understanding. They should be responsible, honest, sincere and maintain the confidentiality of their patients. There exist certain guidelines and laws that guide the conduct of medical personnel. Various types of medicine systems have been practices in India for ages and provide safer alternatives to allopathic treatment. A number of colleges and courses are available for receiving training and degrees for specialized fields of medicine. Though India has made strides in the field of medicine, we still have a long way to go in terms of improving accessibility and quality of medical services.

11.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the professionalization of health personnel

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- Describe the types of medicines in India such as Ayurveda, Siddha, Unani, Homeopathy, Naturopathy and Yoga
- Examine the challenges for medical education and logistics of training
- Analyze illness as a deviance, the concept of Sick Role and the Labelling Theory
- Explain the concept of health stratification

11.2 OVERVIEW OF PROFESSIONALIZATION OF HEALTH PERSONNEL

The medical profession is a noble and public-oriented profession that survives by practice and observance of several rules and regulations of conduct that are guided by moral, ethical, legal and human values. Around 2500 years ago in the fifth century BC, the "Hippocratic oath", the first ever code of medical ethics, was laid down by Hippocrates, a physician from Greece. With an increase in the number of qualified doctors it has become more important to have a clear understanding of medicolegal issues. Laws that govern the administration of hospitals ensure that the necessary registration processes should be followed to ensure compliance during the periodic inspections by accreditation bodies. There are some other laws also pertaining to the qualifications, practices and conduct of medical professionals, safe medications, patient management, management of employees, environmental safety and medicolegal issues and laws related to the safety of patients, and employees. Besides this, there are certain laws regarding clinical trials, professional and technical training, research, licenses and certifications needed for hospitals. A healthcare administrator should have thorough knowledge of all these laws, policies, regulations and legal procedures to ensure quality care to the patients.

History of Medical Laws in India

Henry Sigerist, a famous medical historian, was of the opinion that public healthcare facilities of the Mohenjo Daro civilization were far better than any other community of that time and since then various duties, rules and responsibilities have been cast on individuals adopting this noble profession. This can also be seen by Charak and Hippocratic Oaths. Kautilya's *Arthashastra* also shows the written proof of regulatory processes. Around 2000 BC, certain laws regarding medical practices, also known as the "Code of Hammurabi" were formulated by Hammurabi, the great king of Babylon. These laws governed the various aspects of health practices, including the fees payable to physician for satisfactory services.

These laws included medical fees to be paid to the doctors and penalties for unsafe and harmful treatments. After this, the Hippocratic Oath was laid down by Hippocrates who is still remembered as the "Father of Western medicine" and since then Hippocratic Oath has been regulating and guiding the code of conduct of doctors. After the Second World War, World Health Organization devised

"The Declaration of Geneva" also known as the modern version of Hippocratic Oath, which is now accepted by medical practitioners at national and international level. East India Company established certain hospitals and brought several physicians and surgeons and British Government implied many rules and regulations. During1600-1913, Lt Colonel DG. Crawfords narrated many cases of indiscipline, malpractices, etc. by doctors and the penalties and punishments were given to them. In 1880, Bombay Medical Act was passed by Grant Medical College Society and the medical council was established and its draft included the appointment of a registrar, maintenance of patient register and penalty for wrong therapies. After this, in 1914, the Bengal Medical Act and Madras Medical Registration Act were constituted. These Acts were followed by the Indian Medical Degree Act which was passed by the Indian Legislative Council in 1916.

In 1933, Indian Medical Council Act was constituted after which the Medical Council of India, a national level statutory body for the medical professionals was established. In 1938, the Bombay Medical Practitioner Act was passed resulting in first legal recognition and registration for the Indian medicinal systems. The first legal recognition and registration for the Indian systems of medicine came when the Bombay Medical Practitioner Act was passed in 1938. In 1947, after the Independence, a new phase of organized health services was inaugurated in country leading to the constitution of new laws, modifications in the colonial laws and creating good institutional infrastructure for the modernization and rapid development of India. With the passage of time, several bills and acts were passed to manage and regulate the healthcare delivery system in the country.

Prerequisites of Medical Practice

- A duly qualified medical professional has to register himself with the medical council of the state of which he has domicile by following the laid down procedures before practicing medicine, dentistry and surgery.
- If a court has sentenced a doctor for any non-bailable offence or guilty of infamous professional conduct, the state medical council can warn, refuse to register, remove or re-enter the name of that doctor in the register.
- The provisions pertaining to the offences and professional misconducts that can be brought to the State/Medical Council of India have been given in the "Indian Medical Council Regulation 2002". A medical practitioner is given full opportunity to defend in person or through an advocate before sentencing any action against him.

Laws Applicable to Hospitals

I. Laws that govern the commissioning of hospital

There are certain laws that ensure the provision of all the necessary facilities in the hospitals after undergoing required registration formalities. These laws also make sure that the services are completely safe for the people using them and at least,

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the minimum essential infrastructure exists depending upon the type of the hospitals and volume of anticipated patient footfall and hospitals are subjected to periodic inspections from time to time to ensure full compliance.

These laws are given in Table 11.1 below:

Table 11.1 *Laws that Govern the Commissioning of Hospital*

S. No	Law
1.	Atomic Energy Act 1962
2.	Companies Act 1956
3.	Indian Electricity Rules 1956
4.	Electricity Act 1998
5.	Electricity Rules 1956
6.	Indian Telegraph Act 1885
7.	National Building Act 2005
8.	Radiation Protection Certificate from BARC
9.	Society Registration Act
10.	Urban Land Act 1976
11.	Indian Boilers Act 1923
12.	The Clinical Establishment (Registration and Regulation) Bill 2007

Many states have also enacted their own legislations for regulating clinical establishments. These are given below in Table 11.2.

Table 11.2 *State-wise legislations for regulation of clinical establishments*

i.	Bombay Nursing Homes Registration Act, 1949
ii.	Delhi Lift Rules 1942
iii.	Bombay Lift Act 1939
iv.	The AP Private Medical Care Establishments Act
v.	Delhi Nursing Homes Registration Act, 1953
vi.	Delhi Electricity Regulatory Commission (Grant of consent for captive power plants) Regulations 2002
vii.	Delhi Fire Prevention and Fire Safety Act 1986, and Fire Safety Rule 1987
viii.	Fire Safety Rule 1987
ix.	Orissa Clinical Establishment (Control and Regulation) Act, 1991)
x.	Punjab State Nursing Home Registration Act, 1991
xi.	Manipur Nursing Home and Clinics Registration Act, 1992
xii.	Sikkim Clinical Establishments, Act 1995
xiii.	Nagaland Health Care Establishments Act, 1997
xiv.	MP Clinical Establishments Regulation Act

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II. Laws that govern the qualifications/practices and conduct of healthcare professionals

These regulations govern the qualifications of healthcare professionals employed in the hospital to ensure that they are qualified and have necessary skills and licenses to carry out certain specific technical jobs within the prescribed limits of competence and according to the standard codes of conduct and ethics. Registration councils have been enacted to verify the credentials of healthcare professionals and in case of observance of any professional misconduct, these councils may take appropriate actions against them.

These laws are enlisted in Table 11.3.

Table 11.3 *Laws to govern the qualifications/practices and conduct of healthcare professionals*

S. No.	Laws
1.	The Indian Medical Council Act 1956
2.	Indian Medical Council (Professional Conduct, Etiquette, and Ethics Regulations 2002)
3.	Indian Medical degree Act 1916
4.	Indian Nursing Council Act 1947
5.	Delhi Nursing Council Act 1997
6.	The Dentist's Act 1948
7.	AICTE Rules for Technicians 1987
8.	The Paramedical and Physiotherapy Central Councils Bill 2007
9.	The Apprenticeship Act 1961
10.	The Pharmacy Act 1948

III. Laws to govern the sale, storage and safety of drugs and other medical products

These laws are enacted to control the sale of drugs, various chemicals, blood and blood products. These laws also control and prevent the misuse of dangerous drugs and drug adulteration, regulate and ensure the sale of medications through proper licenses and take punitive actions against the offenders. These laws are depicted in Table 11.4.

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Table 11.4 Laws to govern the sale, storage and safety of drugs and other medical products

S No	Laws
1.	Blood Bank Regulation Under Drugs and Cosmetics (2nd Amendment) Rules 1999
2.	Sales of Good Act 1930
3.	Drugs and Cosmetics Act 1940 and Amendment Act 1982
4.	Excise permit to store the spirit, Central Excise Act 1944
5.	IPC Section 274 (Adulteration of drugs), Sec 275 (Sale of Adulterated drug), Sec 276 (Sale of drug as different drug or preparation), Sec 284 (negligent conduct with regard to poisonous substances)
6.	Narcotics and Psychotropic Substances Act
7.	Pharmacy Act 1948
8.	The Drug and Cosmetics Rule 1945
9.	The Drugs Control Act 1950
10.	VAT Act/Central Sales Tax Act 1956

IV. Laws that govern patient management

These laws are enacted for setting norms and standards to govern the conduct of healthcare practice, regulate/prohibit certain unsafe procedures, prevent wrong practices and control epidemics and diseases. These laws also deal with the proper management of medico-legal cases and other aspects like dying declaration, conduction of autopsy and all types of medical negligence cases. These laws are enlisted in Table 11.5.

Table 11.5 Laws that govern patient management

S No	Laws
1.	Birth and Deaths and Marriage Registration Act 1886
2.	Drugs and Magic Remedies (Objectionable) Advertisement Act
3.	Guardians and Wards Act 1890
4.	Indian Lunacy Act 1912
5.	Law of Contract Section 13 (for consent)
6.	Lepers' Act
7.	PNDT Act 1994 and Preconception and Prenatal Diagnostic Tech (prohibition of sex selection) Rules 1996 (Amendment Act 2002)
8.	The Epidemic Disease Act 1897
9.	Transplantation of Human Organ Act 1994, Rules 1995
10.	The Medical Termination of Pregnancy Act 1971

V. Laws enacted for the safety of environment

These laws are aimed to protect the environment by preventing air pollution, water pollution, noise pollution and punishing the offenders. A list of these laws is given in Table 11.6.

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Table 11.6 *Laws enacted for the safety of environment*

S No	Laws
1.	Air (prevention and control of pollution) Act 1981
2.	Biomedical Waste Management Handling Rules 1998 (Amended on 2000)
3.	Environment Protection Act and Rule1986, 1996
4.	NOC from Pollution Control Board
5.	Noise Pollution Control Rule 2000
6.	Public Health Bye Law 1959
7.	Water (prevention and control of pollution) Act 1974
8.	Delhi Municipal Corporation (malaria and other mosquito borne diseases) Bye Law 1975
9.	Prohibition of Smoking in Public Places Rules 2008
10.	The Cigarettes and Other Tobacco Products (prohibition of advertisement and regulation of trade and commerce, production, supply and distribution) Bill 2003
11.	IPC Section 278 (making atmosphere noxious to health), Sec 269 (negligent act likely to spread infection or disease dangerous to life, unlawfully or negligently)

VI. Laws enacted for employment and manpower management

These laws deal with the regulation of employment norms for manpower including their salaries and other benefits, rules regarding service and disputes and grievance redressal system. These are listed in Table 11.7.

Table 11.7 *Laws enacted for the employment and manpower management*

S No	Laws
1.	Bombay Labour Welfare Fund Act 1953
2.	Citizenship Act 1955
3.	Delhi Shops and Establishment Act 1954
4.	Employee Provident Fund and Miscellaneous Provision Act 1952
5.	Employment Exchange (compulsory notification of vacancies)
6.	Act 1959
7.	Equal Remuneration Act 1976
8.	ESI Act 1948
9.	ESI Rules 1950
10.	Indian Trades Union Act 1926
11.	Industrial Dispute Act 1947
12.	Maternity Benefits Act 1961
13.	Minimum Wages Act 1948
14.	Negotiable Instrument Act 1881
15.	Payment of Bonus Act 1956
16.	Payment of Gratuity Act 1972
17.	Payment of Wedges Act 1936
18.	Persons with Disabilities Act 1995
19.	PPF Act 1968

VII. Laws enacted for the safety of patients, public and staff within the hospital premises

There are certain laws that deal with the safety of patients, and staff with regard to the facilities and services against any accidental hazards that may endanger the lives and the liability of management for any violation. These laws are listed in Table 11.8.

Table 11.8 *Laws enacted for the safety of patients, public and staff within the hospital premises*

S No	Law
	The Radiation Surveillance Procedures for the Medical Application of Radiation 1989, Radiation Protection Rules 1971
	AERB Safety Code no. AERB/SC/Med-2(rev-1) 2001
	Arms Act 1950
	Boilers Act 1923
	Explosive Act 1884 (for diesel storage)
	Gas Cylinder Rules 2004
	Insecticide Act 1968
	IPC Section 336 (act endangering life or personal safety of others), Sec 337 (causing hurt by act endangering life or personal safety of others), Sec 338 (causing grievous hurt by act endangering the life and personal safety of others).
	NOC from chief fire office
	Periodic fitness certificate for operation of lifts
	Petroleum Act and Storage Rules 2002
	Prevention of Food Adulteration Act 1954
	The Indian Fatal Accidents Act 1955
	The Tamil Nadu Medicare Service Persons and Medicare Service Institutions (prevention of violence and damage or loss to property) Act 2008

VIII. Laws regarding Medico-legal issues

There are certain laws that govern the doctor-patient relationships and medico-legal issues pertaining to negligence of duty. These are enlisted in Table 11.9.

Table 11.9 *Laws regarding medicolegal issues*

S. No	Laws
1.	Consumer Protection Act 1986
2.	Indian Evidence Act
3.	Law of privileged communication
4.	Law of torts
5.	IPC Section 52 (good faith), Sec 80 (accident in doing lawful act), Sec 89 (for insane & children), Sec 90 (consent under fear) , Sec 92 (good faith/consent), Sec 93 (communication in good faith).

IX. Laws enacted for professional education and research

These laws are enacted for the regulation of standards of professional education and training of medical professionals and managing research related activities. They are depicted in Table 11.10.

Table 11.10 *Laws enacted for professional education and research*

S No	Laws
1.	MCI rules for MBBS, PG and internship training
2.	National board of examination rules for DNB training
3.	ICMR rules governing medical research
4.	NCI rules for nursing training
5.	Ethical Guidelines for Biomedical Research on Human Subjects, 2000

X. Laws that govern the business aspects of hospitals

There are some rules that are applicable to the hospitals regarding their business aspects. These are presented in Table 11.11 below.

Table 14.11 *Laws that govern the business aspects of hospitals*

S No	Laws
1.	Cable Television Network Act 1995
2.	Charitable and Religious Trusts Act 1920
3.	Contracts Act 1982
4.	Copyright Act 1982
5.	Custom Act 1962
6.	FEMA 1999
7.	Gift Tax Act 1958
8.	Income Tax Act 1961
9.	Insurance Act 1938
10.	Sales of Good Act 1930

Introduction to Medical and Paramedical Education

In India, medical treatment and medical education started from the era of the Rishi-Munis. In India, seven types of medicines are available. The Ayurveda is the oldest medicine in India. Treatment and education of this medicine is in practice from the Rishi-Muni age. Every medical therapy has its own system of treating patients. Thus, in India there are six types of medicines.

- Allopathy
- Ayurveda
- Homeopathy

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- Siddha
- Unani
- Naturopathy and Yoga Therapy

1. Allopathy

Allopathy is a modern scientific system to study human body and diseases by conventional means. This system is well developed and is accepted all over the world. Allopathic medicine is that branch of medical practice which utilizes pharmacologically vital agents or physical involvement to treat or subside symptoms of diseases or conditions.

The Medical Council of India (MCI) is an ordinance body formed under the stipulation of the Indian Medical Council (IMC) in1956. The core objectives of the Council are:

- Maintaining consistent standards of medical education throughout the country
- Dictating minimum requirements for the foundation of medical colleges
- Commendation to initiate new medical colleges or new courses
- Acknowledgement of medical qualifications
- Sustenance of Indian Medical Register
- Enforcing ethical protocols of proper conduct by medical professionals

Present Scenario of Medical Education in India

Sr. No.	Types of Colleges	Number of Medical colleges	Number of seats
1	Govt. Medical Colleges	182	30,455
2	Private Medical Colleges	214	36,615
	Total	396	67,070

Total post-graduate medical colleges in India:

Sr No.	Type of College	No. of Seats
1	Govt. Medical College	17,921
2	Private Medical College	10,794
	Total Seats	28,715

Undergraduate courses: Three phase framework

- First - Preclinical MBBS of 12 months
- Second - Para clinical MBBS of 18 months
- Third - Clinical MBBS of 24 months

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Post graduate medical courses:

SUBJECT	DEGREE	DIPLOMA
Anesthesia	MD/DNB	Diploma in anesthesia
Anatomy	M.S./DNB/M.Sc.	-
Biochemistry	MD/DNB/MSc	-
Community Medicine	M.D/DNB	DCM or DPH
Dermatology	M.D/DNB	DDVL or DVD
ENT	MS/DNB	DLO
Family Medicine	MD/DNB	-
Forensic Medicine	MS/DNB	Diploma in FM
General Medicine	MD/DNB	-
General Surgery	MS/DNB	-
Microbiology	MD/DNB/M.Sc.	-
Nuclear Medicine	MD/DNB	DRM
Orthopedics	MS/DNB	D Ortho
Ophthalmology	MS/DNB	DO
Obstetrics & Gynecology	MS/DNB	DGO
Palliative Medicine	MD	-
Pathology	MD/DNB	DCP
Pharmacology	MD/DNB/MSc	-
Physiology	MD/DNB/MSc	-
Pediatrics	MD/DNB	DCH
Psychiatrics	MD/DNB	DPM
Pulmonology	MD/DNB	DTCD
Radio diagnosis	MD/DNB	DMRD
Radio therapy	MD/DNB	DMRT
Tropical	MD	DTMH

Source: https://en.m.wikipedia.org

Two year courses on allied health sciences:

- Hospital Administration
- Epidemiology
- Bioengineering
- Nano-engineering
- Molecular biology, etc.

Three year research for a regular PhD degree on successful completion of requisites.

Dental

This branch is related only to dental diseases and dental education providing knowledge about how to control diseases and conditions pertaining to teeth. Current scenario regarding the amount of Dentists in India is a very important issue to be considered. Are we having a dearth of dentists in India?

To answer this question, one should know the geographical spread of dentists in India. The problem is not with the number of dental surgeons, but their distribution.

Majority of the dentists reside in metropolitan cities in India. However, larger part of our population resides in rural areas. Inadequate and poor oral care services are available in rural areas.

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Importance of oral health education is also very low among the rural population, thus resulting in a despairing condition. Despite the existence of a large number of qualified dental professionals in our country, basic oral health care, and interventions are also not accessible to a huge amount of population. There is high amount of tobacco abuse in various forms raising the number of oral cancer, gum problems and dental tooth decay.

Indian dental schools receive both B.D.S. degree from their University at the time of graduation along with a certificate of successful completion of the 5-year course, 4 years of academics and 1 year internship. They can then get a state approved license to practice.

Total Undergraduate Dental Colleges in India

Total Post Graduate Dental Colleges in India:

There are 241 dental colleges having post-graduation course out of which 36 are government colleges.

Recently, there were a total of 26,000 BDS and 6000 MDS seats in the country, of which only 24,000 seats are filled up for the year 2016–2017, the vacant seats for BDS in government colleges were 184, while in the private colleges, it was 6,243.

In the 2017–2018, the vacant seats in government colleges were 329 and private colleges 4213. Similarly, the vacant seats in the MDS in 2016–2017 in government colleges were 105, while in private colleges, the number was 518.

In 2018–2019, vacant seats in government colleges were 232, while in private dental colleges, it was 1,678. This is largely attributable to increased fee structure particularly in private institutes, National Eligibility cum Entrance Test (NEET) qualification marks and a lack of interest in non-clinical subjects in postgraduate course.

2. Ayurveda

India officially recognizes the system of indigenous medicine and therefore institutionalized a separate department of **AYUSH** which consists of namely: Ayurveda, Unani, Siddha, Homeopathy and Yoga and Naturopathy.

The Central Council of Indian Medicine (CCIM) monitors matters related to AYUSH.

The Ayuvedic treatment is one of the oldest methods in the world. It uses the belief that a balance between body, mind, spirit and social wellbeing constitute perfect health.

Ayurvedic Colleges of India grants the Degree of BAMS (Bachelor of Ayurvedic Medicine & Surgery) at graduation. Duration of BAMS is 51/2 years including 1 year of Internship

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The Post graduate programmes have a duration of 3 years leading to degree of Doctor of Medicine in Ayurveda (M.D.) and Master of Surgery in Ayurveda (M.S.)

MBBS candidates who have completed 1 year of internship, recognized by MCI can do Post Graduate course in Ayurveda.

Post-graduate programs are arranged into 16 branches for Doctorate in Ayurveda. The 16 branches namely are:

- Ayurvedic Sidhants (Fundamental Principals of Ayurveda)
- Ayurvedic Samhita (Treatise)
- Rachna Sharir (Anatomy)
- Kriya Sharir (Physiology)
- Dravya Guna Vigyan (Pharmacology)
- Shastra Bhaishajya Kalpana (Pharmaceuticals)
- Kumar Bharitya (Paediatrics)
- Prasuti Tantra (Obs and Gynae)
- Swastha Vrita (Preventive Medicine)
- Kayachitiksa (Internal Medicine)
- Shalya Tantra (Surgery)
- Shalkya Tantra (Eye and ENT)
- Mano Roga (Psychiatry)
- Panchkarma (detoxification)
- Rog Nidan (Pathology)
- Materia Medica.

Total number of 261 colleges, 72 government and 189 private colleges offer the degree of Bachelor in Ayurveda Medicine and Surgery (BAMS)

3. Unani

The Unani system of medicine also called Greek-Arab medicine is based on the concept of Greek ideology. According to this conventional system, the human body comprises four basic elements, namely: 'Earth, Air, Fire and Water'.

The body liquids consist of four humors which have their own temperatures and the nature and amount of these humors affect health of the body.

- Blood: Wet and Hot
- Phlegm: Hot and Cold
- Yellow bile: Dry and Hot
- Black bile: Dry and Cold

Concept of Health: When the humors are in an equilibrium state, the body operates normally. Health is dependent on six vital elements:

- Air
- Beverage and food

- Sleep and awake time
- Excreta and holding
- Physical activity and relaxation
- Mental activeness & rest

Diagnosis in Unani system is made by examining the pulse, feces and urine along with a physical checkup while treatment options are available in three modes:

- **Regimental approach**: Advising exercise, change of climate, massage therapy, diet and nutrition etc.
- **Pharmacotherapy**: Administration of drugs made from plants, animal or minerals, alone or in combination.
- **Surgery**: Done as the last resort.

Present Education Scenario

In India, Unani Medicine education is supervised by Central Council of Indian Medicine (CCIM).

There are 43 colleges in India imparting Bachelor of Unani Medicine and Surgery (BUMS) degree of 5 ½ years. The candidates learn basic pre-clinical and clinical subjects. BUMS course involves 1 year rotatory internship. Specialized courses can be house job or PG.

PG courses are in two branches – MD in Unani medicine or MS Unani surgery, in one or more of the following branches:

- Internal Medicine
- Principles in Unani system
- Obstetrics and Gynecology
- Pediatrics
- Unani Surgery
- Preventive and Social Medicine
- Pharmacology

Colleges of Unani Medicine in India

There are recognized colleges and institutions both government and private. Some of the leading institutions are:

- Government Unani Medical College, Chennai
- Central Council for Research in Unani Medicine, New Delhi
- National Institute of Unani Medicine, Pune
- Nizamia Tibbia College and Hospital, Hyderabad
- Faculty of Unani Medicine, Jamia Hamdard, Delhi
- Government Unani Medical College, Bangalore
- HSZH Government Unani College, Bhopal

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- Ajmal Khan Tibbia College, AMU, Aligarh
- A & U Tibbia College, Karol Bagh, New Delhi
- Anjuman-i-Islam Tibbia College and Hospital, Mumbai
- ZVM Unani College and Hospital, Pune
- Markaz Unani Medical College & Hospital, Calicut
- Tipu Sultan Unani Medical College, Karnataka

Source: Central Council of Indian Medicine: Ministry of AYUSH, Government of India https://www.ccimindia.org/unani-colleges.php

4. Homeopathy

The homeopathy system was a famous system in India and was introduced by Samuel Hahnemann and has been in use in India from the time of Mahabharata some 3500 years ago. Homeopathic medicine has simplicity, is safe, non-toxic and formed on scientific principles. It cures, prevents, promotes and covers rehabilitation. It provides cure for acute and chronic infectious diseases as well as for complicated diseases.

There are currently 186 UG homeopathic medical colleges in India, offering 5 and ½ years BHMS degree, 33 Post Graduate Medical Colleges in which MD in homeopathy is being offered for duration of 3 years in 7 specialties.

- Organon of Medicine and Homeopathic Philosophy
- Homeopathic Materia Medical
- Repertory
- Homeopathic Pharmacy
- Practice of Medicine
- Pediatrics
- Psychiatry

5. Naturopathy and Yoga Sciences

Naturopathy is based on body's own healing power, and therefore encourages self-cleansing and rehabilitation. It emphasizes on immunity, hormones, nerves and elimination of the body to achieve this process. When all the systems are in harmony, body will achieve homeostasis. Naturopathy treats patients in the absence of internal or external intervention. The power of sunlight, earth, water and air are used to speed up the healing. Natural elements are used to treat the ailment by motivating the passive healing ability of nature.

Yoga therapy is a practice of yoga postures, mudras, breathing, massage, healthy diet and other aspects of healthy living habits. These help a person to make use of the self-healing capabilities inbuilt in the human body.

There are seventeen colleges in India that give degree in Bachelor of Naturopathy and Yoga Sciences (BNYS), the course is of 4½ years including 1

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year internship. The topics of study are nutrition therapy, homeopathic medicine, acupuncture, herbal medicine and natural medicine etc.

The degree is recognized by the Council of Naturopathic Medical Education. In the first two years standard medicine knowledge is taught. The first year contains biomedical sciences; the second year contains science of diagnosis. Holistic approaches to body systems and naturopathic modalities are also taught during the first two years. The last two years uncover naturopathic diagnostic techniques and treatment approaches and involve extensive, clinical experience.

MD in Naturopathic Medicine, MD in Yoga Medicine, MD in Acupuncture Medicine and PG Diploma in GO, CH, EM, PM. BNYS Medical Graduates can pursue Post Graduation available in private and government institutions. Postgraduate Diploma is of 2 years and Postgraduate degree of three years.

6. Siddha

Siddha medicine system is used in few parts of South India like Tamil Nadu. It has close association to Ayurvedic medicine but maintains its own identity. The term SIDDHA stands for achievement. SIDDHARS were the pioneers who obtained knowledge in the field of medicine, yoga and meditation.

Before the reign of Aryans in India, a civilization thrived in South India on the banks of river Kaveri. The system of medicine used in this community is the present day Siddha system. The pharmacology of Siddha medicine depends mostly on drugs of metal and minerals whereas Ayurveda used drugs of vegetable origin for treatment.

The concept of Siddha states that matter and energy have enormous role in shaping the nature of the Universe. These two elements are called Siva and Shakti. Matter and energy cannot exist without each other. This science has a concept of 5 elements and 3 doshas applicable to them. Diagnosis in this system is established by examining 8 sites on the human body, namely:

- Pulse (nadi)
- Tongue (na)
- Urine (neer)
- Complexion (varna)
- Voice (swara)
- Eyes (kan)
- Touch (sparisam)
- Faeces (mala)

These diagnostic methods are carried out in more detail compared to ayurvedic medicine.

With close similarity to Ayurvedic medicine, Siddha also believes in ashtanga concept for treatment procedures. Major focus is on the three branches – Pediatrics, Toxicology and Ophthalmology. The treatment methods in Siddha and

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Ayurveda are categorized into and Samana and Sodhana therapy. Siddha contains well known techniques classified under panchakarma therapy, which is not very well developed; just the Vamana therapy has achieved recognition of physicians practicing Siddha.

One of the major classic difference between Siddha and Ayurveda is that the remedial substances in the former one are made of mineral and metal origin, in contrast to the drugs of vegetable origin in the latter.

The remedial drugs in Siddha System are categorized under the following categories:

- *Uppu (Lavanam)* - medicines that can be melted in water and get deciphered when exposed to fire turn into vapor.
- *Pashanam* - medicines that are not soluble in water but still gives off vapor when exposed to fire.
- *Uparasam* - Similar to nava paashanam but has different actions.
- *Uparatnas and Ratna* - it consists of medicines based on precious and semi-precious stones
- *Loham* - metals and metal alloys that do not disseminate in water but melts once exposed to fire and solidifies when cooled.
- *Rasam:* drugs which have soft consistency, they are sublime when exposed to fire and change into little crystals or unstructured powder.
- *Gandhakam - s*ulphur is not soluble in water & burns when exposed to fire.

All compound drugs are prepared from these basic drugs. 35 products are incorporated from the animal family into the remedial drugs. Quantity of plant derived preparations is also incorporated in Siddha medicine and is similar to those used in Ayurvedic medicine.

Paramedical Education System in India: Postgraduate Specialization

Paramedics are trained medical professionals who diagnose any disease in a human body with the help of blood test, X-ray, MRI, CT Scan, Ultrasound etc. In addition, they actually support doctors in providing better treatment by doing various medical checkups and therapies. Therefore, these professionals have become an integral part of the Paramedical sector in India. Even in the coming, there will be high demand for Paramedics professionals in India.

Some Paramedical degree courses

- Bachelor of Physiotherapy
- BSc in Medical Lab Technology
- BSc in X-Ray Technology
- BSc in Radio diagnostics
- BSc in Dialysis

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- BSc in Anaesthesia
- BSc Perfusion Technology
- BSc in Ophthalmology
- BSc in Radiotherapy
- BSc in Critical care technology
- BSc in Medical Record Technology
- BSc in Operation Theatre Technology
- BSc. in Optometry
- Bachelor of Radiation Technology
- Bachelor of Occupational Therapy
- BSc in Medical Imaging Technology
- BSc Nuclear Medicine Technology
- BSc in Audiology and Speech Therapy
- BSc in Respiratory Therapy
- BSc in Renal Dialysis Technology

Some Paramedical diploma courses

- Diploma in X-Ray Technology
- Diploma - Medical Imaging Technology
- Diploma - Physiotherapy
- Diploma - Medical Laboratory
- Auxiliary Nurse Midwife
- Diploma - Operation Theatre Technology
- Diploma - Dialysis Technology

Some Paramedical post graduate degree courses

- Master of Neuro Physiotherapy
- Master in Sports Physiotherapy
- PG Diploma in Medical Radio-diagnosis
- MSc Medical Lab Technology
- PG Diploma in Perfusion Technology
- Masters in Optometry
- Masters in Audiology and Speech Language Pathology

Some Paramedical certificate courses in India

- Certificate in Dialysis Technician
- Certificate in X-Ray Technician
- Certificate in Lab Assistant or Technician
- Certificate in OT Assistant
- Certificate - Electrocardiogram and CT Scan Technician

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- Certificate - Home Health Care
- Certificate - Family Education
- Certificate - Childcare and Nutrition
- Certificate in Rural Health Care

The requirement of Paramedical professionals like Lab Technicians, Radiology Technicians, Physiotherapists and Pharmacists will surely increase. According to a report, Indian Paramedical sector will increase with the growth rate of 16.6 per cent in the coming 5 years.

Challenges for Medical Education and Logistics of Training

India has the greatest number of medical colleges in the entire world, which reflects the level of medical competence that we withhold. However, a major part of our citizens have inadequate access to good health care. A minimal of three checkups during pregnancy is not available for nearly 50 per cent pregnant women of our country. There have been numerous conflicts surrounding the condition of medical education in our country. The challenges of a lacking government hold over the recognition process, dearth of skilled faculty, curriculum with insignificant data.

1. Ratio of doctor to patient is less

A recent study has quoted that 'India has one government doctor for every 11,528 people and one nurse for every 483 people. India has approximately 396 medical colleges with 45,000 graduates passing out every year, whereas it is required that 500 new colleges should come up, producing 1 million doctors every year.'

2. Giving clinical skills more importance

Evaluation system of India is based on the memorizing power of large amount of theoretical knowledge. The exam pattern is still the same, without taking humanity into account. 'Students face question papers having questions which are more of knowledge based than on real clinical cases. One should expect to respond to questions based on clinical cases or various drugs than remembering achievements of a particular individual,' says Dr Ravella.

3. Outdated syllabus and educating style

Everyday new revelations are made in medical field, but the syllabus taught to medical students in India is not updated consistently. Science fields are still separated from each other because of insufficient understanding of how different fields of knowledge can be combined for better understanding and implementation. New aspects of medical science are also rarely taken up.

4. Lack of proficient staff

Faculty in medical organizations is hired based on their qualifications and not based on their clinical experience. This decreases the efficiency of the knowledge which they bestow on their students. Moreover, teachers are not trained regarding teaching

innovations which is a big lack. The salary offered is low which makes only the less talented available. Because of which the more talented prefer a private practice. In government hospitals there is a forever transfer threat.

5. Inequality in infrastructure of different states

A 2010 report revealed inequality in the opportunities for medical education in different parts of the country. Four states - Andhra Pradesh (AP), Karnataka, Maharashtra and Tamil Nadu are having nearly 1.3 lac of total 2.5 lac medical seats available in India.

6. Preference for super specialists

It is impossible to have one genre of doctors to serve all types of health issues especially in a vast country. Some doctors need to be trained for providing suitable healthcare in rural areas, while others are familiar with latest medical technologies for most complex procedures. MBBS students specialize in various fields to get a job because of which research is usually ignored. However, this specialization drive makes the students miss out on knowing about all these aspects. Colleges must familiarize students with all different aspects of medical sciences.

7. Problems with private medical colleges

A law change in the late 19th century made it possible to establish private schools and therefore a lot of medical institutes came up in the country, they got funds from businessmen and politicians, who did not anything about running medical schools. Hundred government medical colleges & 11 private medical colleges existed in 1980, today, the government institutions have doubled while the private institutions have increased by 20 fold. Although this change came up to solve the problem of the dearth of doctors, it made medical education a business.

8. Studying or practicing in other countries

There are nearly 48 thousand Indian doctors who are practicing in the US and nearly 26,000 practicing in the UK. Therefore, India is the largest exporter of medical professionals in the world.

Improvising the system

In order to serve the growing demand of doctors, government needs to take some immediate and strict steps or else India won't be able to cater for its ever growing demand. It will happen only when the medical education is improvised, that the health industry can improvise overall.

- Doctors should be trained by considering their social bearing.
- Intermingling of subjects, innovative educating systems, and universal use of technology in classes is essential
- In order to fulfill rural healthcare needs, students must be familiarized with latest advancements in technology so that good healthcare can be given even from a distance.

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- Students must be trained on holistic approach and whole body healing by combining other medicine systems with modern science.

Economics of Holistic Medicine

Economic evaluation requires information on both the health benefits (ie, effectiveness) and costs of the therapies under consideration. There are many challenges involved in determining the effectiveness of medicine.

- Appropriate and Well-defined Comparators
- Health Outcomes and Quality-adjusted Life-years
- Measuring the Costs

Economic evaluation adds information on costs to the information already available on a therapy's safety and effectiveness. Cost data are essential to allow for efficient resource allocation—i.e. to allow decision makers to identify the distribution of resources (funds, staff, equipment and facilities across various populations) that generates the greatest overall good. Because the results of economic evaluation bring this additional crucial information to a decision, there is sometimes the illusion that the results are "the answer." However, there are many considerations that go into a decision that are beyond the scope of an economic evaluation.

Check Your Progress

1. When did the first legal recognition for Indian systems of medicine come?
2. What do laws enacted for the safety of environment aim to do?
3. What do laws enacted for employment and manpower management deal with?
4. List the treatment options available in the Unani system.
5. Who introduced homoeopathy in India?
6. State the challenges involved in determining the effectiveness of medicine.

11.3 THE PROCESS OF SEEKING MEDICAL CARE AND THE SICK ROLE

Medical care vis-a-vis sick role is discussed broadly under a topic called illness behaviour. It indicates the ways in which symptoms are perceived, evaluated, and acted upon at an individual level. There are many variables in illness behaviour ranging from illness-related, patient-related, and doctor-related variables and a combination of their intricate interplay.

Talcott Parsons, an American sociologist introduced the term 'sick role'. This role allows the sick persons the privilege to be exempted from normal responsibilities and social duties. However, there remains the obligation to try to get well and, therefore to seek qualified help and to cooperate in recovering. In 1960, Mechanic and Volkart

probed the various ways in which people react to physical symptoms and also to the cultural and psycho-social factors that affect reactions. They defined illness behaviour as 'the ways in which given symptoms may be differentially perceived, evaluated, and acted (or not acted) upon by different kinds of persons'. Subsequently, Mechanic provided the following specification: 'Illness behaviour refers to the varying ways individuals respond to bodily indications, how they monitor internal states, define and interpret symptoms, make attributions, take remedial actions and utilize various sources of informal and formal care'.

In the last few decades, research has expressed concern regarding illness perception, health-care seeking behaviour, frequent visits to medical facilities, treatment-seeking behaviour, delay in seeking treatment, and treatment adherence. Studies have shown that the concept of illness behaviour is most likely to provide a unifying framework and deep insights to observations and findings that would otherwise not find much credence and would have remained scattered in the medical literature. The way in which illness behaviour unfolds, it is likely to affect the presentation of diseases and how its diagnosis is to be done, and what course of treatment to be adopted. Accurately assessing and interpreting illness behaviour by healthcare providers can help in improving final outcomes.

With the development of modern medicine, in countries like the U.S., a biomedical model is followed in which illness is defined as an abnormal biological affliction or mental abnormality, that is characterized by a

I. Cause
II. Characteristic train of symptoms
III. Method of treatment

In a typical biomedical model, symptoms are diagnosed and it is followed by the prescribed treatment. Following the biomedical model, modern healthcare has developed technology-driven solutions through the diagnosis and treatment of acute and infectious diseases. The treatment of chronic illness however does not follow the same pattern. The basic nature of the chronic illness makes it non-curable completely, or not necessarily treatable. More and more people across the world are surviving chronic conditions for an extended period. Modern medicines have therefore become increasingly concerned with how individuals live with and manage chronic illness. Studies by Wasserman and Hinote (2012) state that "Medicine's accomplishments in treating infectious disease, both in the clinic and through public health measures, initiated the epidemiological transition, where chronic illnesses became the primary mortality threats in developed countries, mainly due to increased life expectancy (Cockerham 2007).... This is especially problematic because the profiles of chronic and infectious disease are paradigmatically different. Therefore, the modern conception of medicine, which is matched so well with infectious disease, likely will increasingly fall short as chronic illnesses constitute a greater share of the epidemiological picture". (Wasserman and Hinote 2012:147). In this context, it is relevant to state that if modern medicine intends to really understand how individuals manage and live with the chronic disease if it wants to promote the well-being of individuals and to bring

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about a reduction in the cost of ineffective healthcare, studies must be directed towards examining the means through which chronically ill people obtain general and experiential knowledge both consciously and subconsciously, to shape their illness behaviour.

11.4 ILLNESS AS A DEVIANCE AND THE FUNCTIONALIST APPROACH

Functionalism is a body of theories in social sciences in general. Functionalism is mainly concerned with the maintenance of social order, equilibrium, or stability in human society. By social order is meant - a state of normalcy in human society, especially when social institutions are functional.

Generally, health is viewed as a prerequisite for the proper functioning of society by the functionalists. For a society to develop and flourish it is imperative that health as a social value remains steady. This is essential for society's survival and development. Illness has been explained as deviance, an infraction on the ability of the individual to carry out daily activities. As per Lupton (2003), illness indicates a failure to conform to expectations of the society and norms in some way. It is therefore an unnatural state of the human body that may cause both physical and social dysfunction and therefore must be cured as early as possible. The medical practitioners and healthcare institutions perform the functional role to help in the control of the disease and assist people in recovering from illness and return to the normal role in society.

The functionalist perspective states that health is vital to the stability of society and therefore sickness is construed as a sanctioned form of deviance. Talcott Parsons was a pioneer in this field and he was the first to discuss this in terms of the sick role (in 1951), i.e. the expectation patterns that emerge and define the appropriate behaviour for the sick and those who attend to and take care of them.

Parson categorically states that the sick person has a specific role with both responsibilities and rights. At the outset, it is to be understood that a person has not chosen to be sick so he or she should not be treated as responsible for their particular condition. Per se, the sick person has the right of being exempted from normal social roles. The sick person is not required to perform their normal duties and fulfill the obligations that a healthy person is supposed to shoulder. They can avoid their day-to-day responsibilities without censure. However, it is to be noted that this exemption is only temporary and is directly connected to the severity of illness. In order to be considered sick the person has to be legitimately diagnosed as sick by a physician, ie., the physician must certify that the sickness is genuine.

The responsibility of a sick person is twofold in the sense that he or she has to make a genuine effort to get well and should get medical intervention from a physician. If the person is ill for a period that is beyond the normal period of illness for that particular ailment then they may be stigmatized.

Parson in his research states emphatically that since the sick are not in a position to fulfill their normal societal roles, their sickness in effect weakens the society. It is therefore necessary at times to bring the behaviour of a sick person back in line with normal expectations. This model of health designates a definite role to the doctors, who act as gatekeepers, deciding who is healthy and who is sick- a relationship in which the doctor is all-powerful. It is a question of debate whether the doctor should at all be allowed so much power and also what can be done by the doctor if people who are actually sick are unwilling to relinquish their responsibilities and obligations for various reasons like - personal, social, financial, limited insurance, etc.

Functionalism has some specific views as shown in the table below.

Basic views of functionalism

View of society	The system, collective consciousness, harmony, integration or cooperation, shared values
Level of analysis	Macro, group, or social aggregate
Key concepts	Structures, functions, roles, dysfunctions, social system, division of labor
View of the individual	People are shaped by norms and values or collective sentiments
View of the social order	Determined by collective values or consensus
View of social change	Evolutionary—gradual or in piecemeal or stages
View on disease or illness	It affects role allocation and performance, illness as a form of social deviance and leads to social vacuums, dysfunctional/immense consequences for social aggregate, health care institutions and other agents of the society can function to reduce disease burden

August Conte and Herbert Spencer had an interesting observation to make when they stated that human society is like a living organism. This is essentially the first major feature of functionalism and is known as an organismic analogy. The human society supposedly resembles a social organism much like a biological organism. It is a social system with interdependent and interrelated parts. All these parts function for the smooth functioning of society. If, one part malfunctions then the entire body will get affected.

Check Your Progress

7. How did Mechanic and Volkart define 'illness behaviour'?
8. What is functionalism mainly concerned with?
9. In what sense is the responsibility of a patient twofold?

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11.5 THE SICK ROLE

Talcott Parsons is credited with the development of the theory of "sick role" in the context of medical sociology. This development was done by Parsons in association with psychoanalysis. Per se, Sick Role is a concept that concerns the social aspects of becoming ill and the privileges and obligations that accompany it. The moot point as put across by Parsons is that a sick person is incapable of being considered a productive member of society, hence it is a kind of deviation that needs to be addressed by the medical profession. The best way to understand the illness sociologically, as per Parsons, is to view it as a deviant phenomenon that disrupts the social fabric of the social function of the society, To elaborate on the concept, an individual who has fallen ill is not only physically indisposed but is conforming to the specifically patterned social role of being sick.

The concept took its roots in 1951 when Talcott Parsons explained that the particular rights and responsibilities of those who are sick are explained through the Sick role theory. People who are diagnosed as being indisposed, usually cannot function in the same manner as that of a person in good health and society adapts to this situation and allows for a reasonable amount of deviation from behaviour that would be conforming to a healthy person. While speaking on deviance, Parsons explains that it is about going against social expectations, because a sick person simply cannot follow the regular pattern of behaviour of the normal people. People are in the general course, expected to be productive units of society. In circumstances where the sick person is unable to discharge his duties- like attending office, or going to school, or carrying out family commitments, the deviance is approved by the community or authority. Students not going to school due to illness will be condoned as they are confined to their bed, even though the school sees it as a deviation.

For a deviation to be sanctioned, a medical practitioner must certify that the concerned person is actually sick. This certification will validate the position of the person being actually sick. This validation or legitimization proves the illness and also justifies the need to take a lenient view of the issue. An example would be the doctor's certificate that one can submit in school to prove the need to skip classes.

As per Parsons, there are two rights and two responsibilities that a sick person has-

Rights

a. A patient has the right not to be blamed for his/her illness.
b. A right to be given concessions by others in regard to normal obligations.

Responsibilities

a. Getting well soon should be a priority.
b. To seek appropriate treatment for his or her condition.

These rights and responsibilities are applicable only for the tenure when the person is indisposed. Thus, this status is temporary in nature. The respective details of these expectations will differ based on the seriousness and criticality of the illness and how disruptive it is as far as functioning in day-to-day life is considered.

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11.6 LABELLING THEORY AND ILLNESS AS A SOCIAL DEVIANCE

Much of the work on social definitions of illness comes from the qualitative (or interpretive) approach within sociology known as symbolic interactionism, or more simply 'interactionism' (Hewitt, 1991). The central idea of the approach is that social action is based on shared meanings and negotiations between people. Language is central to this process because it provides common definitions and meanings which allow individuals to see their behaviour in the same ways as others do. Social life is possible because people talk to each other, can agree upon the values, rules and meanings of activities, and can control their behaviour self-consciously. This is, they can treat themselves as 'an object' and reflect upon both their past behaviour and what they intend to do so in the future. They can also compare themselves and their actions to what other people think about them and expect from them. The starting point in extending these ideas to the analysis of illness is that one can interpret and give meanings to the signs and symptoms of disease.

It is these interpretations which are central to the understanding of illness behaviour. As we will see, not all disease is defined as illness. Lemert (1972) emphasizes that it is not the change or difference in a person's feelings or behaviour itself which is crucial, but the reactions of individuals to it. He distinguishes between **'primary'** and **'secondary' deviance**. That is, departures from normal states which are interpreted and dealt with as part of normal social behaviour (primary deviance), and those which are interpreted in a way which leads to changes in normal social behaviour (secondary deviance). In the context of illness, it appears that the primary deviance of disease symptomatology is frequently disregarded or 'normalized'. For example, tiredness is sometimes defined as an inevitable consequence of physical activity (primary deviance), and at other times it is seen as a sign of illness (secondary deviance). A particularly striking development of Lemert's approach which has been influential within the sociology of health and illness is the 'Labelling theory' (Schur, 1979). Labelling theory emphasizes the powerful influence of social definitions upon the behaviour of health professionals and ordinary people, paying particular attention to possibly negative consequences

11.7 HEALTH STRATIFICATION: CASTE AND CLASS BASED INEQUALITIES

Stratification can be broadly defined as the arrangement or classification of something into different groups. Health stratification is actually a form of social stratification

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that sociologists used to describe the system of social standing. Per se Social Stratification is about society's categorization of its population into groups depending on the socioeconomic criteria based on wealth, income, race, power, and education. In this particular section, we will discuss stratification based on caste and class.

In the Indian context, the caste and class of a household provide an additional dimension in deciphering the vulnerability and poverty status. India is typically a country that is perennially under-provided for health care and tools like health insurance etc. are mostly unheard-of in the rural and semi-urban areas. The dependence on the private health sector to cater to the increased demands of healthcare further undermines the health priorities of the marginalized and especially the backward castes and tribes.

Lack of effective access to health care by marginalized groups typically occurs across all societies. The impact is more pronounced in developing nations. Social exclusion and deprivation based on caste and class have a profound impact on access to health care and on health. Demand-side barriers coupled with supply-side constraints are key determinants in the population's access to health-care, especially for the economically and socially vulnerable groups.

India is a country with a wide variety of people from various walks of life, so naturally, it is not an easy task to stratify the population into proper subgroups for the purpose of analyzing inter-group inequality and disparity. The basic parameters for stratifying the population are – social class/caste, economic class, gender, region, age-group, etc. Among these parameters, caste and income class are the two most potent variables of stratification. Caste in India is an identifier that indicates a closed, hereditary, and immutable group that has a traditional association with an occupation and a particular position on the social ladder. Socioeconomic status is an open and non-immutable characteristic of a household or group of households.

Social inequalities in health in India can be judged using variables like – gender, caste, religion, education, wealth, and urban-rural residence. Caste is something unique to India and needs some elaboration – caste is based on the respondent's self-identification whether belonging to a scheduled case, scheduled tribe, other backward class, and other castes. These communities have been segregated and denied access to a range of facilities like temples, drinking water wells, restaurants, and even civic facilities.

Most of India's backward caste population is confined to rural areas that accounts for roughly 73% of the population that has access to only 25% of the country's health care resources. The health care system in India is organized along very unstructured lines with the bulk of the service being provided by the private sector. The lack of health insurance is a major damper that leaves people impoverished due to the huge out-of-pocket medical expenses.

A study that was carried out in Kerala, India, revealed that even though the state was superior in its social and cultural health achievements, inequality was still

visible in health achievements between social groups. Inter-caste disparity continues to underlie overall disparity on various counts including health in the state of Kerala.

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The study states that caste-based inequality in household health expenditure points to unequal access to quality health care by different caste groups. This inequality adversely affects those households that need high health care and are afflicted by chronic health care needs. Households consisting of the most marginalized castes inevitably require a financial support system to counter impoverishing health costs.

A detailed study on the aspect of health stratification and the inequalities meted out based on caste and class, titled "Health Inequalities in India: The Axes of Stratification" was made by S.V.Subramanian, Leland K. Ackerson, Malavika A. Subramanyam, and Kavita Shivaramakrishnan in 2008. The study is relevant even today.

The study focused on analyzing the patterns of social inequalities in health disparities across the following outcomes:

Mortality

Analyzing the relevant household data, it was concluded that there was a strong connection between the standard of living and all-cause mortality. It was observed that as the standard of living deteriorated, mortality went up in a systematic manner. It was also observed that there existed a connection between social caste and mortality, with scheduled tribes being more vulnerable as compared to other castes. IT was also concluded that gender differentials caused more men to die than women.

Morbidity

Morbidity was measured by ascertaining whether household members suffering from asthma, tuberculosis, malaria, or jaundice. It was found that morbidity and standard of living are strongly related. Education also has a strong relation to morbidities. People with no formal education were 61 percent more likely to be reported for morbidities as compared to those with the education of 13 years or more. Moreover, men are more likely to report morbidities than women.

Poor Health Behaviours

Certain health-related bad behaviours like chewing tobacco, smoking, or consuming alcohol are related to caste, education, and standard of living. Scheduled tribes have been found to be more prone to consuming tobacco or alcohol when compared to scheduled castes or other tribes. Similarly, people with little or no formal education, or with a very low standard of living are likely to consume three times more alcohol or tobacco.

The health inequalities in India are not entirely inevitable or immutable. Sustained and concerted efforts to alleviate poverty by improving standards of living, and raising education levels can go a long way to mitigate the class inequalities. However, for this, a proper public policy needs to be in place. There is a need to

target programs and interventions that are simultaneously oriented towards those in the lowest rungs of the caste system and those that are the most marginalized to address different socioeconomic measures across the society. The implications of the social structure and its role in mediating relationships between health and the overall economic development of India need to be seriously deliberated upon while changing and choosing, drafting health policies.

Check Your Progress

10. What is the central idea of interactionism?
11. What are primary and secondary deviances?
12. What are the key determinants in the population's access to health-care?

11.8 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The first legal recognition and registration for the Indian systems of medicine came when the Bombay Medical Practitioner Act was passed in 1938.
2. These laws are aimed to protect the environment by preventing air pollution, water pollution, noise pollution and punishing the offenders.
3. The laws enacted for employment and manpower management deal with the regulation of employment norms for manpower including their salaries and other benefits, rules regarding service and disputes and grievance redressal system.
4. Treatment options are available in Unani in three modes:
   - **(i) Regimental approach**: Advising exercise, change of climate, massage therapy, diet and nutrition etc.
   - **(ii) Pharmacotherapy**: Administration of drugs made from plants, animal or minerals, alone or in combination.
   - **(iii) Surgery**: Done as the last resort.
5. The homeopathy system was a famous system in India and was introduced by Samuel Hahnemann and has been in use in India from the time of Mahabharata some 3500 years ago.
6. There are many challenges involved in determining the effectiveness of medicine. These are:
   - Appropriate and Well-defined Comparators
   - Health Outcomes and Quality-adjusted Life-years
   - Measuring the Costs
7. Mechanic and Volkart defined illness behaviour as 'the ways in which given symptoms may be differentially perceived, evaluated, and acted (or not acted) upon by different kinds of persons'.

8. Functionalism is mainly concerned with the maintenance of social order, equilibrium, or stability in human society. By social order is meant - a state of normalcy in human society, especially when social institutions are functional.
9. The responsibility of a sick person is twofold in the sense that he or she has to make a genuine effort to get well and should get medical intervention from a physician.
10. The central idea of interactionism is that social action is based on shared meanings and negotiations between people.
11. Departures from normal states which are interpreted and dealt with as part of normal social behaviour (primary deviance), and those which are interpreted in a way which leads to changes in normal social behaviour (secondary deviance).
12. Demand-side barriers coupled with supply-side constraints are key determinants in the population's access to health-care, especially for the economically and socially vulnerable groups.

11.9 SUMMARY

- Around 2500 years ago in the fifth century BC, the "Hippocratic oath", the first ever code of medical ethics, was laid down by Hippocrates, a physician from Greece.
- In 1933, the Indian Medical Council Act was constituted after which the Medical Council of India, a national level statutory body for the medical professionals was established. In 1938, the Bombay Medical Practitioner Act was passed resulting in first legal recognition and registration for the Indian medicinal systems.
- Laws to govern the sale, storage and safety of drugs and other medical products are enacted to control the sale of drugs, various chemicals, blood and blood products. These laws also control and prevent the misuse of dangerous drugs and drug adulteration, regulate and ensure the sale of medications through proper licenses and take punitive actions against the offenders.
- In India, there are six types of medicines:
  - o Allopathy
  - o Ayurveda
  - o Homeopathy
  - o Siddha
  - o Unani
  - o Naturopathy and Yoga Therapy
- The Medical Council of India (MCI) is an ordinance body formed under the stipulation of the Indian Medical Council (IMC) in1956.
- Despite the existence of a large number of qualified dental professionals in our country, basic oral health care, and interventions are also not accessible

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to a huge amount of population. There is high amount of tobacco abuse in various forms raising the number of oral cancer, gum problems and dental tooth decay.

- India officially recognizes the system of indigenous medicine and therefore institutionalized a separate department of **AYUSH** which consists of namely: Ayurveda, Unani, Siddha, Homeopathy and Yoga and Naturopathy. The Central Council of Indian Medicine (CCIM) monitors matters related to AYUSH.
- The Unani system of medicine also called Greek-Arab medicine is based on the concept of Greek ideology. According to this conventional system, the human body comprises four basic elements, namely: 'Earth, Air, Fire and Water'.
- There are 43 colleges in India imparting Bachelor of Unani Medicine and Surgery (BUMS) degree of 5 ½ years. The candidates learn basic pre-clinical and clinical subjects.
- The homeopathy system was a famous system in India and was introduced by Samuel Hahnemann and has been in use in India from the time of Mahabharata some 3500 years ago. Homeopathic medicine has simplicity, is safe, non-toxic and formed on scientific principles.
- Naturopathy is based on body's own healing power, and therefore encourages self-cleansing and rehabilitation. It emphasizes on immunity, hormones, nerves and elimination of the body to achieve this process.
- The concept of Siddha states that matter and energy have enormous role in shaping the nature of the Universe. These two elements are called Siva and Shakti. Matter and energy cannot exist without each other. This science has a concept of 5 elements and 3 doshas applicable to them.
- One of the major classic difference between Siddha and Ayurveda is that the remedial substances in the former one are made of mineral and metal origin, in contrast to the drugs of vegetable origin in the latter.
- Paramedics are trained medical professionals who diagnose any disease in a human body with the help of blood test, X-ray, MRI, CT Scan, Ultrasound etc.
- Everyday new revelations are made in medical field, but the syllabus taught to medical students in India is not updated consistently. Science fields are still separated from each other because of insufficient understanding of how different fields of knowledge can be combined for better understanding and implementation.
- Economic evaluation adds information on costs to the information already available on a therapy's safety and effectiveness. Cost data are essential to allow for efficient resource allocation—i.e. to allow decision makers to identify the distribution of resources (funds, staff, equipment and facilities across various populations) that generates the greatest overall good.

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- Talcott Parsons, an American sociologist introduced the term 'sick role'. This role allows the sick persons the privilege to be exempted from normal responsibilities and social duties.
- In a typical biomedical model, symptoms are diagnosed and it is followed by the prescribed treatment. Following the biomedical model, modern healthcare has developed technology-driven solutions through the diagnosis and treatment of acute and infectious diseases.
- Functionalism is a body of theories in social sciences in general. Functionalism is mainly concerned with the maintenance of social order, equilibrium, or stability in human society. By social order is meant - a state of normalcy in human society, especially when social institutions are functional.
- Parson in his research states emphatically that since the sick are not in a position to fulfill their normal societal roles, their sickness in effect weakens the society. It is therefore necessary at times to bring the behaviour of a sick person back in line with normal expectations.
- For a deviation to be sanctioned, a medical practitioner must certify that the concerned person is actually sick. This certification will validate the position of the person being actually sick.
- The central idea of interactionism is that social action is based on shared meanings and negotiations between people. Language is central to this process because it provides common definitions and meanings which allow individuals to see their behaviour in the same ways as others do.
- Health Stratification is actually a form of social stratification that sociologists used to describe the system of social standing.
- Social inequalities in health in India can be judged using variables like – gender, caste, religion, education, wealth, and urban-rural residence.
- The health inequalities in India are not entirely inevitable or immutable. Sustained and concerted efforts to alleviate poverty by improving standards of living, and raising education levels can go a long way to mitigate the class inequalities.

11.10 KEY WORDS

- **Homeostasis:** It is the state of steady internal, physical, and chemical conditions maintained by living systems. This is the condition of optimal functioning for the organism and includes many variables, such as body temperature and fluid balance, being kept within certain pre-set limits.
- **Interactionism:** It is a theoretical perspective that derives social processes (such as conflict, cooperation, identity formation) from human interaction. It is the study of how individuals shape society and are shaped by society through meaning that arises in interactions.

- **Toxicology:** It is a scientific discipline that involves the study of the adverse effects of chemical substances on living organisms and the practice of diagnosing and treating exposures to toxins and toxicants.

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11.11 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. List the prerequisites of medical practice.
2. Write a short note on laws that govern patient management.
3. List the core objectives of the Medical Council of India (MCI).
4. Name the five branches of Post-graduate programs for Doctorate in Ayurveda.
5. Elaborate upon the categories of remedial drugs in the Siddha system.
6. What do Wasserman and Hinote state with regard to the accomplishments of medicine?
7. What are the basic parameters for stratifying the population?

Long-Answer Questions

1. Analyze the history of medical laws in India.
2. Discuss any five laws applicable to hospitals.
3. Explain the challenges for medical education and logistics of training in India.
4. Elaborate upon the outcomes of the study titled 'Health Inequalities in India: The Axes of Stratification'.

11.12 FURTHER READINGS

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UNIT 12 MANAGEMENT OF HEALTH CARE SERVICES

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Structure

12.0 INTRODUCTION

Health care services need to be managed efficiently for the purpose of providing better services and facilities to patients. Management of health care services includes the supervision, planning and overseeing of all the activities related to medical institutions and various medical departments. With an organized system of management, the accessibility, speed and quality of services can be improved significantly.

12.1 OBJECTIVES

After going through this unit, you will be able to:

- Analyze the management of health care services in India including both private and public services
- Discuss the evolution of public health systems in India
- Examine the process of health planning in India and the recommendations of various commissions

12.2 PUBLIC AND PRIVATE HEALTH CARE SERVICES IN INDIA

The present health systems in India evolved from the Bhore Committee Report in 1946. The committee recommended a three-tier healthcare system for providing curative and preventive healthcare services through health workers on the payroll of the government. It was also recommended that private practice should be limited

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so that primary care becomes independent of socioeconomic conditions of the people. However, public health care systems were not found enough to provide quality care healthcare services to growing Indian population thereby resulting in the simultaneous emergence of private healthcare services.

The governance and operational aspects of the Indian healthcare system is divided between both the union governments and state governments because of federal government system. The national programs like National AIDS Control Program, program to prevent and control communicable diseases and making guidelines and policies are implemented by the Union Ministry of Health and Family Welfare which can be adopted by the state governments. Ministry also helps the states in the prevention and control of epidemics and endemics by providing technical assistance. State government controls the areas like public health, sanitation and hospitals, etc. Some areas like population control, provision of medical education, quality control management techniques in the manufacturing medicines and prevention and elimination of food adulteration come under both union and state governments.

In India, mixed healthcare system is present consisting of both public and private hospitals. However, private health service providers are mostly concentrated in urban areas of the country and provide secondary and tertiary health services. Till 1980s, healthcare services were mainly provided by the government and charitable hospitals. But the last two decades have witnessed the emergence of a large number of corporate and private hospitals in India. The private healthcare sector encompasses fifty eight per cent of the hospitals, twenty nine per cent of the hospital beds and eighty one per cent of the doctors in India. India is ranked among the top twenty countries of the world concerning private spending on healthcare. Employers contribute to around 9% on private care, 5%-10% is contributed by health insurance companies while 82% is spent personally from the patients. People in India are choosing private hospitals for medical services because of many reasons. Firstly, the infrastructural facilities in the public hospitals are inadequate with unpleasant surroundings and long waiting lines. Secondly, many medicines and diagnostic tests are unavailable in the government hospitals due to which patients are forced to go to private hospitals and laboratories. Third, a doctor in government hospital has to examine more than 100 patients is one OPD session.

Classification of Hospitals

Hospitals can be classified in various ways as given below:

1. According to the WHO

(a) **Regional hospitals**: Highly advanced, complex and specialized medical procedures are provided in these hospitals. They serve a larger area in comparison to the local hospitals. For example: Government Medical Colleges and Hospitals.

(b) **District/Intermediate hospitals**: These hospitals provide healthcare services in major specialties in a particular locality.

(c) **Rural hospitals**: These hospitals are located in remote areas and have less number of beds and there is a provision of limited number of services.

2. According to objective

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(a) **General hospitals**: These hospitals provide healthcare services for almost all types of medical conditions, diseases, illness, injuries and deformities, etc. Other services include maternity services, neonatal and child care services laboratory investigations, diagnostic imaging facilities, emergency services and pharmacy, etc. These hospitals should be equipped with the facilities that are required to support certified healthcare professionals rendering their services. Usually, these hospitals do not possess super-specialized medical care services.

(b) **Speciality hospitals**: These hospitals specialize in a specific condition or disease like eye hospitals like Venu Eye Institute and Centre for Sight in Delhi NCR for eye disorders, cancer hospital like Sri Shankara Cancer Hospital and Research Centre Karnataka and Apollo Speciality Cancer Hospital in Tamil Nadu for treatment of cancers.

(c) **Teaching cum research hospitals**: These hospitals serve as teaching and research centers for doctors and other healthcare professionals and are attached with medical colleges and universities. For example AIIMS New Delhi, CMC (Christian Medical College) Vellore, AFMC (Armed Forces Medical College) Pune, etc.

3. According to administration/control/funding

(a) **Government or public hospitals**: These hospitals are under the administration and control of the government and provide either free healthcare services to the patients or at nominal rates. They receive funding from the government and run under the Ministry of Health or any university.

(b) **Non-government or private hospitals**: These hospitals are owned by an individual who may be a physician or a group of physicians or by private organizations. Main objective of these hospitals is to earn profit.

(c) **Semi government hospitals:** These are hospitals that are run by both the Government and a private entity.

(d) **Corporate hospitals**: A hospital which is run by a corporation with an intention to expand in the form of hospital chain in the same way it has expanded itself into a corporate unit is termed as a corporate hospital. These hospitals follow the regulations of the Companies Act.

4. According to length/duration of stay

(a) Short stay hospitals (Patient stay < 30 days): Patients stay for less than 30 days in these hospitals for the treatment and management of acute diseases like ulcers, pneumonia, etc.

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(b) Long stay hospitals (Patient stay > 30 days): Patients stay for more than 30 days in these hospitals

5. According to type of medical staff

(a) Closed staff hospitals: In these hospitals all the physicians are on the staff panel of the hospitals and they are responsible for diagnosis and treatment of patients. Doctors that are not on the staff panel do not have any access to the hospital.

(b) Open staff hospitals: In these hospitals any doctor can request to use the hospital facilities irrespective of their hospital affiliation i.e. other physicians who are not on staff panel of the hospital may also admit and treat the patients.

6. According to bed size/capacity

(a) Small sized hospitals (upto 100 beds)

(b) Medium sized hospitals (> 100 beds to < 300 beds)

(c) Large sized hospitals (> 300 beds)

7. According to type of care

(a) Primary care: It is the basic health care given on day to day basis to the patients by the healthcare service providers who act as first point of contact for the patients and also coordinates with other specialists if required. Services provided by these hospitals include family planning, endemic disease control, immunization, treatment and management of injuries, providing health education and ensuring sufficient availability of safe drinking water. Primary Health Centers and sub centers provide primary care in rural areas, while in urban areas Family Welfare Centers provide these services in India.

(b) Secondary care: It is the second level of healthcare delivery system, when from primary health care patients are referred for obtaining specialized treatment. The Secondary healthcare centers in India include the District hospitals and Community Healthcare Centers at the block level.

(c) Tertiary care: It is the third tier of healthcare system where specialized care is given on receiving referrals from the primary and secondary care centers. Specialized and exclusive units for Intensive Care, modern and advanced diagnostic equipment and specialized healthcare professionals are the important attributes of tertiary health care. This service in India is provided by the medical colleges and research institutes.

8. According to teaching affiliation

(a) Teaching hospitals: These are the hospitals that are attached with colleges for providing medical education. They are primarily aimed at providing teaching based on medical research rather than healthcare services.

(b) Non-teaching hospitals: These hospitals are aimed to provide clinical care to the patients.

9. According to medicine systems

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(a) Allopathic hospitals: Ayurvedic hospitals
(b) Homeopathic hospitals
(c) Unani hospitals

Emergence of corporate hospitals

Around twenty years ago, the private sector was ruled by solo medical practitioners, nursing homes, healthcare facilities run by charitable trusts and small hospitals and the services provided by them were of best quality. After technological advancements in healthcare sector smaller healthcare organizations have become comparatively less able to compete. Larger corporations like pharmaceutical companies, IT companies and rich NRIs started investing in healthcare sector which are still dominating the market. Large hospitals owned by doctors trained in foreign countries started providing services at high prices that can only be afforded by the foreigners and the rich Indians. Globalization has also played a very significant role in the growth of corporate hospitals in India. The private hospitals in India offer good quality treatment at much less price comparable to that of developed countries which has made it a favourable destination for medical tourists seeking medical treatment at an affordable price. Large number of medical tourists from Africa, Saudi Arabia, Bangladesh, Afghanistan, Pakistan and Middle East are coming to India for availing complex healthcare services like cardiac surgeries, liver transplantation, joint replacement surgeries which are not available in their home countries. Also patients from developed countries like United Kingdom, United States of America and Europe come to India to avoid long waiting lists for the medical procedures.

Factors Supporting Corporate Hospitals

The healthcare sector in mid 80s gained recognition as an industry giving rise to more possibility of investments from the financial institutions. The import duty on medical and diagnostic equipment and technology was also decreased by the government thereby providing ample opportunities for growth and development of healthcare sector. Increase in the literacy rate, income level and media intervention led to more awareness regarding health and regular health check-ups became a necessity which contributed to the growth of corporate hospitals. Certain pharmaceutical companies like Max India, entered this sector as it is related to their business. Also, expansion of the insurance sector in India provided opportunities for private healthcare providers to expand their chain.

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Check Your Progress

1. State two programs implemented by the Union Ministry of Health and Family Welfare.
2. Which areas come under both union and state governments?
3. What is primary care?

12.3 EVOLUTION OF PUBLIC HEALTH SYSTEMS IN INDIA: COMMITTEES

Various public healthcare initiatives in India were introduced by the British during pre-independence era including 'Quarantine Act' in 1825. In 1859, the need of safe drinking water and environmental sanitation was pointed out by the Public Health Commission, so that epidemics could be prevented. Sanitary commissioners were appointed in 1864 in Bombay, Bengal, and Madras for studying the healthcare concerns and initiating measures for improving the sanitary practices. Following this, in 1885 'Local Self-Government Act' was passed.

In 1919, health administration was decentralized with 'Montague-Chelmsford constitutional reforms'. Following this, the gaps in the coverage of health services were acknowledged and the responsibilities for the same were proclaimed; suitable actions were thus, recommended, but resources were not provided for implementation. In 1940, the National Planning Committee adopted the resolution based on the recommendations of Sokheys Committee that is, the preventive and curative functions should be integrated with training of health workers. Bhore committee was then set up in 1943, which laid down the structure on which the healthcare framework was subsequently built in India after independence. After the introduction of Panchayati Raj, the healthcare system in the country, which was initially the top down system was transformed into bottom up decentralized community based system due to bureaucracy in the government, which was propagated by Mahatma Gandhi. After independence, lots of improvements were made in the quality and provision of healthcare services to the community. In 1950, Planning Commission was established by the government and system of five year plan was started for the country's social and economic development, with health being an integral part. Apart from planning commission, various committees were also instituted by the government for reviewing existing healthcare conditions.

Salient Features of Various Committees

There were various committees, which came into existence solely for the purpose of providing an efficient healthcare delivery system.

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Bhore Committee (1943-1946)

Before independence, in 1938, the 'National Planning Commission' was constituted by the INC (Indian National Congress) in the country for promoting, preventing, and curative healthcare services. The British Empire at that time realized the significance of Public Health and established the 'Health Survey and Development Committee', in 1943 chaired by Sir Joseph Bhore. The committee was given the responsibility of surveying the health conditions of the provinces and healthcare organizations in India and to provide recommendations for further development. In 1946, the committee recommended that preventive and curative healthcare services should be integrated and primary health centres should be established in rural areas. Other important recommendations of the Bhore committee are:

- The development of primary health centres for the delivery of comprehensive health services to the rural India. Each PHC should cater to a population of 40,000 with the secondary health centre (now called community health centre) to serve as a supervisory, coordinating, and referral institution.
- In the long term (3 million plan), the PHC would have a 75 bedded hospital for a population of 10,000 to 20,000.
- It also reviewed the system of medical education and research and included compulsory three months training in community medicine.
- Committee proposed the development of National Programmes of health services for the country.

This document laid the utmost emphasis on primary health care; it is not a surprise then that primary health care was later on recognized as the key strategy to achieve 'Health for All (HFA) by 2000' during Alma-Ata conference. The Bhore committee model was based on the allopathic system of medicine. The traditional health practices and indigenous system of medicine prevalent in rural India, which had great influence and were part of their socio-cultural milieu were not included in the model proposed by Bhore committee. The approach was not entirely decentralized but had a top down approach. However, it provided a readymade model at the time of independence and thus, was adopted as a blueprint for both health policy and development of the country.

Mudaliar Committee (1962)

In the course of second five year plan, it was decided by the government that the health requirements and resources in the country should be reviewed, so that important guidelines for national health planning can be formulated. To review the progress of recommendations of Bhore committee, 'Health Survey and Planning Committee' was formed in 1959, under the chairmanship of Dr A. Lakshmanswami Mudaliar to make recommendations for the future course of actions for the development and extension of healthcare services. It was admitted that at least half the country is still devoid of the basic healthcare facilities and a great irregularity

in the distribution of hospitals and beds exist in rural regions. It was also pointed out by the committee that there is an inadequacy in the quality of services provided by PHCs, along with poor functioning, unsatisfactory referral system, and lack of staff because of lack of resources. Important recommendations made by the Mudaliar committee were:

- Strengthening of existing PHCs and development of referral centres should be done before new centres are established
- Strengthening of sub-divisional and district hospitals
- Integration of medical and health services
- It also suggested the constitution of an All India Health Service in the pattern of Indian Administrative service.

Chadah Committee (1963)

DGHS of that time, Dr MS Chadha, was given the responsibility of reviewing the specifications of National Malaria Eradication Program and PHCs. Important recommendations of the Chadah committee were:

- Strict monitoring and vigilance in the implementation of NMEP is the responsibility of general health services at all levels that is, health workers of PHC, CHC, and ZP.
- One basic health worker (now called Multi-Purpose worker) for every 10,000 population was recommended.
- Basic health workers should visit house to house once in a month to implement anti-malaria preventative measures.
- Basic Health workers should take additional duties of collection of vital statistics, counsel on family planning, etc.

Mukherji Committee (1965)

National Malaria Eradication Program and Family planning program suffered a set-back when basic healthcare workers were recommended to take on additional duties and responsibilities of multipurpose workers. So, a committee was appointed under the chairmanship of Shri Mukherji, Healthcare Secretary of that time, for reviewing the healthcare system at all levels from the view point of financial planning and manpower requirement. Important recommendations of the Mukherji committee were:

- Strengthening of the administrative set up at different levels from PHC to state health services
- Separate staff was recommended for family planning program
- Basic health workers to be utilized for all duties except for family planning.

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Jungalwalla Committee (1967)

Central Council of Health in 1967 appointed 'Committee on integration of Health Services' headed by Dr N. Jungalwalla, who was the Director, National Institute of Health Administration and Education at that time. Important recommendations of the Jungalwalla committee were:

- Integrated health services with Unified cadre include common seniority, recognition of extra qualifications, equal pay for equal work, no private practise, special pay for specialized services, improvement in their service conditions, etc.
- Medical care of the sick and conventional public health programmes functioning under single administrator

Kartar Singh Committee (1973)

The committee headed by Shri Kartar Singh, who was the Additional Secretary of MOH and Family Planning, was established to review and provide recommendations regarding the framework for integrated health services at supervisory and peripheral levels. Its aim was to review the feasibility of 'bi purpose and multipurpose workers' in the field. Important recommendations of the Kartar Singh committee were:

- It recommended Female Health Worker in place of ANM and Male Health Worker in place of malaria surveillance worker, along with addition of vaccinators, health education assistants, and family planning health assistants.

The committee proposed a PHC per 50,000 population with 16 sub-centres, each covering a population of 3000-3500. Each sub-centre needs to have one male and one female health worker.

- There should be one male and one female health supervisor at PHC to monitor and supervise the activities of staffs of 3-4 sub-centres.
- The MO in charge of PHC will be the overall in charge of all peripheral staff.
- Training for all workers engaged in the field of health, family planning, and nutrition should be integrated.

Shrivastav Committee (1974-75)

This committee was convened in 1974 by GOI and is also known as 'Group on Medical Education and Support Manpower'. It gave rise to the concept of community participation in the healthcare sector that is, 'people's health in people's hand'. Formed under the chairmanship of Dr J B Shrivastav, Director General Health Services, this committee gave the following recommendations:

- Creation of Village Health Guide (VHG) and participation of community health volunteers from the community itself like teachers, postmasters, gram

sevaks, who can provide comprehensive health services as paraprofessionals.

- Primary health care should be provided within the community itself through specially trained workers, so that the health of the people is placed in the hands of the people themselves.
- Creation of MPW and Health Assistants (HA) with the VHG and MO being in charge of PHC.

On the basis of the above recommendations, in 1977-78, Rural Health Scheme was introduced by the government and the training program of community health workers was started. The important steps were:

- Involvement of medical colleges in health care of selected PHCs with the objective of reorienting medical education according to rural population called Reorientation of Medical education (ROME). It led to teaching and training of undergraduate students and interns at PHCs.
- Training of village health guides and utilising their services in the general health service system.

Shivaraman Committee Health Report

A committee on 'Basic Rural Doctors' was convened under the guidance of Shri Shivaraman, the member of planning commission of that time. It was recommended by the committee that a countrywide cadre of basic rural doctors comprising of trained paraprofessionals should be established to expand healthcare service delivery to the rural communities.

V Ramalingaswamy Committee Health Report

This committee was established under the chairmanship of Dr V Ramalingaswamy, DGHS. Following were the recommendation of the committee:

- Involvement of community in health planning and health programme implementation
- 30 bedded hospital for every 1 lakh population
- Integration of health services at all levels
- Redefine the role of doctor in the community
- Recommended that PHC and District health centres should be under the control of three tier Panchayati Raj System

Bajaj Committee Health Report (1986)

An expert committee for health manpower planning, production, and management was convened under the chairmanship of Dr J.S. Bajaj, member of Planning Commission to solve the issues of health manpower planning, production and management. Important recommendations of the Bajaj committee were:

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- Recommended the formulation of National Health Manpower planning based on realistic survey
- Educational Commission for health sciences should be developed on the lines of UGC.
- Recommended National and Medical education policy, in which teachers are trained in health education science technology.
- Uniform standard of medical and health science education by establishing universities of health sciences in all states
- Establishment of health manpower cells both at state and central level
- Vocational courses in paramedical sciences to get more health manpower.

Krishnan Committee Health Report (1992)

This committee headed by Dr Krishnan was formed to review the performance, achievements, and progress of the previous health committee reports and also provides constructive criticism. The committee addressed the urban healthcare issues and formulated Health Post Scheme for slums in urban areas. It was recommended that there should be one voluntary health worker (VHW) per 2,000 population with an honorarium of ‘ 100. Specific outlines are given in this report regarding the services provided by the health post. These services have been categorised into curative, outreach, family planning, preventive, and support and referral services. Outreach services include elementary education, motivating people to adopt family planning, and health education.

Check Your Progress

4. List two recommendations of the Bhore Committee.
5. Why was the ‘Health Survey and Planning Committee’ formed in 1959?
6. When did the National Malaria Eradication Program and Family planning program suffer a setback?
7. Why was the Kartar Singh Committee established?

12.4 HEALTH PLANNING IN INDIA: PLANNING COMMISSION

By health planning, we mean an orderly process of defining national health problems, identifying the unmet needs, surveying the resources to meet them, and establishing the priority goals to accomplish the purpose of the proposed programme. In India, health planning was initiated by the Planning Commission (now called NITI Aayog). The Planning Commission was set up to promote a rapid rise in the standard of living of the people by efficient exploitation of the resources of the country, increasing production and offering opportunities to all for employment in the service of the

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community. In terms of health, the broad objectives of The Planning Commission were as follows:

- Control or eradication of major communicable diseases
- Strengthening of basic health services through establishment of PHCs and SCs
- Population control
- Development of health manpower resources

In pursuance of these objectives, the Planning Commission formulated Five-Year Plans. You will learn about the goals of these Five-Year Plans in the next unit. Briefly, the functions of Health and Family Welfare Division have evolved over the Plan periods based on the goals envisaged in the Five Year Plans.

The focus of health policies upto 5th Five year Plan was on Control of communicable diseases like TB, Malaria and RCH Programmes and population control, self-sufficiency in drugs and equipments.

From 6th Plan onwards health policies aimed at improving health infrastructure in the rural areas augmenting health human resources. The National Health Policy 2002 aimed at achieving an acceptable standard of health for the general population of the country. Keeping in line with this broad objective, the Eleventh Five Year Plan had set upon itself the goal of achieving good health for people, especially the poor and the underprivileged. To achieve the objective, a comprehensive approach was advocated, which included improvements in individual health care, public health, sanitation, clean drinking water, access to food and knowledge of hygiene and feeding practices.

To achieve this goal, time bound goals were set for the Eleventh Plan period which were:

- Reducing Maternal Mortality Ratio (MMR) to 1 per 1000 live births. Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births. Reducing Total Fertility Rate (TFR) to 2.1.
- Providing clean drinking water for all by 2009 and ensuring no slip- backs. Reducing malnutrition among children of age group 0-3 years to half its present level.
- Reducing anaemia among women and girls by 50%.
- Raising the sex ratio for age group 0-6 to 935 by 2011-12 and 950 by 2016-17.

Though, there has been progress on all these fronts, except child sex ratio, the goals have not been fully met. Low public spending on health (1% of GDP), high out-of-pocket payments (71%) is leading to impoverishment of people. The major thrust in this direction is the National Rural Hearth Mission (NRHM) which aims at major qualitative improvements in standards of public health and health care in the rural areas through strengthening of institutions, community participation,

decentralization and innovative methods of reaching all habitations. Simultaneously, provision of tertiary health care and increasing health human resources to ensure availability of larger number of health care providers has engaged the attention of the planners during the Twelfth Plan.

Planning Commission constituted a High Level Expert Group (HLEG) on universal health coverage, seven Working Groups and Two Steering Committees to define the appropriate strategy for the Health sector for the Twelfth Plan. It identified the following problems with the Health Sector:

Identifying Structural Problems: The health care system in the country suffers from inadequate funding. There are several structural problems too, like, the lack of integration between disease control and other programmes in the social sector, sub-optimal use of traditional systems of Medicines, weak regulatory-systems for drugs as well as for medical practice, and poor capacity in public health management. A sound health system also requires the active participation of communities in preventive and promotive health care, on which the progress has been uneven.

National Health Outcome Goals for the 12th Plan: The Steering Committee on Health in its Report has recommended health system for the 12th Plan should prioritize the making of the system responsive to the needs of citizens, and the attainment of financial protection for the health care of households. More specifically, the national health outcome goals, which are meant to reflect the broader commitments during the 12th Plan should be the following:

Reduction of Infant Mortality Rate (IMR) to 25: At the past rate of decline of 2 points per year, India is projected to have an IMR of 38 by 2015 and 34 by 2017. An achievement of the MDG of reducing IMR to 27 by 2015 would require further acceleration of this historical rate of decline. If this accelerated rate is sustained, the country can achieve an IMR of 25 by 2017.

Reduction of Maternal Mortality Ratio (MMR) to 100: At the recent rate of decline of 5.5% per annum India is projected to have an MMR of 143 by 2015 and 127 by 2017. An achievement of the Millennium Development Goal (MDG) of reducing MMR to 109 by 2015 would require an acceleration of this historical rate of decline. At this accelerated rate of decline, the country can achieve an MMR of 100 2017

Reduction of Total Fertility Rate (TFR) to 2.1: India is on track for the achievement of a TFR target of 2.1 by 2017, which is necessary to achieve net replacement level of unity, and realize the long cherished goal of the National Health Policy, 1983 and National Population Policy of 2000.

Prevention and reduction of underweight children under 3 years to 23%: Underweight children are at an increased risk of mortality and morbidity. At the current rate of decline, the prevalence of underweight children is expected to be 29% by 2015, and 27% by 2017. An achievement of the MDG of reducing

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undernourished children under 3 years to 26% by 2015 would require an acceleration of this historical rate of decline. If this accelerated rate is sustained, the country can achieve an under 3 child under nutrition level of 23% by 2017. This particular health outcome has a very direct bearing on the broader commitment to security of life, as do MMR, IMR, anaemia and child sex ratio.

Prevention and reduction of anaemia among women aged 15-49 years to 28%: Anaemia, an underlying determinant of maternal mortality and low birth weight, is preventable and treatable by a very simple intervention. The prevalence of anaemia has shown a rising trend (58.8% in 2007, DLHS), which needs to be reversed and steeply reduced to 28%, which is half the current levels, by the end of the 12th Plan.

Raising child sex ratio in the 0-6 year age group from 914 to 935: Like anaemia, child sex ratio is another important indicator which has been showing a deteriorating trend, and needs to be targeted for priority attention.

Prevention and reduction of burden of Communicable and Non-Communicable diseases (including mental illnesses) and injuries: State wise and national targets for each of these conditions will be set by the Ministry of Health and Family Welfare (MoHFW) as robust systems are put in place to measure their burden. Broadly, the goals of communicable diseases shall be as indicated as in the Table

National Health Goals for Communicable Disease

Disease	12th Plan Goal
Tuberculosis	Reduce annual incidence and mortality by half
Leprosy	Reduce prevalence to < 1/10,000 pop. and incidence to zero in all districts,
Malaria	Annual Malaria Incidence of < 1/1000
Filariasis	<1% microfilaria prevalence in all districts
Dengue	Sustaining case fatality rate of <1%
Chikungunya	Containment of outbreaks
Japanese Encephalitis	Reduction in JE mortality by 30%
Kala-azar	<1% microfilaria prevalence in all districts
HIV/AIDS	Reduce new infections to zero and provide comprehensive care and support to all persons living with HIV/AIDS and treatment services for all those who require it.

Reduction of poor households' out of pocket expenditure: Out of pocket expenditure on health care is a burden on poor families, leads to impoverishment and a regressive system of financing. Increase in public health spending to 2.1% of GDP by the end of the 12th Plan, cost free access to essential medicines in public facilities, regulatory measures proposed in the 12th Plan are likely to lead to increase in share of public spending. The 12th Plan measures will also aim to reduce out of pocket spending as a proportion of private spending on health.

Check Your Progress

8. List the broad objectives of the Planning Commission.
9. What was the focus of health policies upto 5th Five Year Plan?
10. What did the National Health Policy, 2002 aim at?

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12.5 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The national programs like National AIDS Control Program, program to prevent and control communicable diseases and making guidelines and policies are implemented by the Union Ministry of Health and Family Welfare which can be adopted by the state governments.
2. Some areas like population control, provision of medical education, quality control management techniques in the manufacturing medicines and prevention and elimination of food adulteration come under both union and state governments.
3. Primary care is the basic health care given on day to day basis to the patients by the healthcare service providers who act as first point of contact for the patients and also coordinates with other specialists if required.
4. Two recommendations of the Bhore Committee were:
   (i) In the long term (3 million plan), the PHC would have a 75 bedded hospital for a population of 10,000 to 20,000.
   (ii) It also reviewed the system of medical education and research and included compulsory three months training in community medicine.
5. To review the progress of recommendations of Bhore committee, 'Health Survey and Planning Committee' was formed in 1959, under the chairmanship of Dr A. Lakshmanswami Mudaliar to make recommendations for the future course of actions for the development and extension of healthcare services.
6. National Malaria Eradication Program and Family planning program suffered a set-back when basic healthcare workers were recommended to take on additional duties and responsibilities of multipurpose workers.
7. The committee headed by Shri Kartar Singh, who was the Additional Secretary of MOH and Family Planning, was established to review and provide recommendations regarding the framework for integrated health services at supervisory and peripheral levels.
8. The broad objectives of the Planning Commission were as follows:
   - Control or eradication of major communicable diseases

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- Strengthening of basic health services through establishment of PHCs and SCs
- Population control
- Development of health manpower resources

9. The focus of health policies upto 5th Five year Plan was on Control of communicable diseases like TB, Malaria and RCH Programmes and population control, self-sufficiency in drugs and equipments.
10. The National Health Policy, 2002 aimed at achieving an acceptable standard of health for the general population of the country.

12.6 SUMMARY

- The present health systems in India evolved from the Bhore Committee Report in 1946. The committee recommended a three-tier healthcare system for providing curative and preventive healthcare services through health workers on the payroll of the government.
- In India, mixed healthcare system is present consisting of both public and private hospitals. However, private health service providers are mostly concentrated in urban areas of the country and provide secondary and tertiary health services. Till 1980s, healthcare services were mainly provided by the government and charitable hospitals.
- General hospitals provide healthcare services for almost all types of medical conditions, diseases, illness, injuries and deformities, etc. Other services include maternity services, neonatal and child care services laboratory investigations, diagnostic imaging facilities, emergency services and pharmacy, etc.
- Teachung cum Research hospitals serve as teaching and research centers for doctors and other healthcare professionals and are attached with medical colleges and universities. For example AIIMS New Delhi, CMC (Christian Medical College) Vellore, AFMC (Armed Forces Medical College) Pune, etc.
- Tertiary care is the third tier of healthcare system where specialized care is given on receiving referrals from the primary and secondary care centers. Specialized and exclusive units for Intensive Care, modern and advanced diagnostic equipment and specialized healthcare professionals are the important attributes of tertiary health care.
- After the introduction of Panchayati Raj, the healthcare system in the country, which was initially the top down system was transformed into bottom up decentralized community based system due to bureaucracy in the government, which was propagated by Mahatma Gandhi.

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- To review the progress of recommendations of Bhore committee, 'Health Survey and Planning Committee' was formed in 1959, under the chairmanship of Dr A. Lakshmanswami Mudaliar to make recommendations for the future course of actions for the development and extension of healthcare services.
- Shrivastav committee was convened in 1974 by GOI and is also known as 'Group on Medical Education and Support Manpower'. It gave rise to the concept of community participation in the healthcare sector that is, 'people's health in people's hand'.
- An expert committee for health manpower planning, production, and management was convened under the chairmanship of Dr J.S. Bajaj, member of Planning Commission to solve the issues of health manpower planning, production and management.
- From 6th Plan onwards health policies aimed at improving health infrastructure in the rural areas augmenting health human resources. The National Health Policy 2002 aimed at achieving an acceptable standard of health for the general population of the country.
- Planning Commission constituted a High Level Expert Group (HLEG) on universal health coverage, seven Working Groups and Two Steering Committees to define the appropriate strategy for the Health sector for the Twelfth Plan.
- The Steering Committee on Health in its Report has recommended health system for the 12th Plan should prioritize the making of the system responsive to the needs of citizens, and the attainment of financial protection for the health care of households.
- The prevalence of anaemia has shown a rising trend (58.8% in 2007, DLHS), which needs to be reversed and steeply reduced to 28%, which is half the current levels, by the end of the 12th Plan.

12.7 KEY WORDS

- **Maternal Mortality Ratio** (**MMR**): It is the ratio of the number of maternal deaths during a given time period per 100,000 live births during the same time-period.
- **Corporate Hospital:** It is a hospital which is run by a corporation with an intention to expand in the form of hospital chain in the same way it has expanded itself into a corporate unit is termed as a corporate hospital. These hospitals follow the regulations of the Companies Act.
- **Globalization:** It is the process of interaction and integration among people, companies, and governments worldwide.

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- **Total Fertility Rate (TFR):** The number of children who would be born per woman (or per 1,000 women) if she/they were to pass through the childbearing years bearing children according to a current schedule of age-specific fertility rates.
- **Non-Communicable Diseases:** These are a diverse group of chronic diseases that are not communicable such as stroke, cancer, diabetes etc.

12.8 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. Write a short note on the Bhore Committee Report recommendations.
2. Why are people choosing private hospitals for medical services?
3. Why has India become a favourable destination for medical tourists seeking medical treatment?
4. Mention some public healthcare initiatives introduced by the British during pre-independence era in India.
5. List the important recommendations made by the Mudaliar Committee.

Long-Answer Questions

1. Discuss the classification of hospitals on the basis of objective.
2. Analyze the categories of hospitals according to the type of care.
3. Examine the recommendations of the Kartar Singh Committee.
4. Elaborate upon some problems identified by the Planning Commission in the health sector.

12.9 FURTHER READINGS

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BLOCK - V
FIVE YEAR PLANS AND CONTEMPORARY ISSUES IN HEALTH SERVICES MANAGEMENT

UNIT 13 FIVE YEAR PLANS AND HEALTH POLICIES

Structure

13.0 INTRODUCTION

The First Five Year Plan was launched in 1951 with the objective of developing the primary sector in the country. It was based on a socialist perspective of the then Prime Minister Jawaharlal Nehru. Subsequent plans focused on various aspects ranging from the growth of the economy, self-sufficiency in food grains, attaining equality and social justice in society, modernization and so on. Along with the plans, health policies were formulated to lay emphasis on improving people's health so that they reach a level of optimum productivity and a good quality of life. Most recent of these is the National Health Policy, 2017 which aims at prioritizing the role of the government in improving the health care system in the country.

13.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the Five Year Plans implemented in India since independence
- Analyze the National Health Policies of India
- Explain the public health system in India at the Central, State, District and Village level
- Understand the current trends in private health care in India

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13.2 FIVE YEAR PLANS

Though the planned economic development in India began in 1951 with the inception of First Five Year Plan, theoretical efforts had begun much earlier, even prior to independence. Setting up of National Planning Committee by Indian National Congress in 1938, The Bombay Plan & Gandhian Plan in 1944, Peoples Plan in 1945 (by post war reconstruction Committee of Indian Trade Union), Sarvodaya Plan in 1950 by Jaiprakash Narayan were steps in this direction.

Five-Year Plans (FYPs) are centralized and integrated national economic programs. Joseph Stalin implemented the first FYP in the Soviet Union in the late 1920s. Most communist states and several capitalist countries subsequently have adopted them. China and India both continue to use FYPs, although China renamed its Eleventh FYP, from 2006 to 2010, a guideline (guihua), rather than a plan (jihua), to signify the central government's more hands-off approach to development.

After independence, India launched its First FYP in 1951, under socialist influence of first Prime Minister Jawaharlal Nehru. The process began with setting up of Planning Commission in March 1950 in pursuance of declared objectives of the Government to promote a rapid rise in the standard of living of the people by efficient exploitation of the resources of the country, increasing production and offering opportunities to all for employment in the service of the community. The Planning Commission was charged with the responsibility of making assessment of all resources of the country, augmenting deficient resources, formulating plans for the most effective and balanced utilisation of resources and determining priorities.

The first Five-year Plan was launched in 1951 and two subsequent five-year plans were formulated till 1965, when there was a break because of the Indo-Pakistan Conflict. Two successive years of drought, devaluation of the currency, a general rise in prices and erosion of resources disrupted the planning process and after three Annual Plans between 1966 and 1969, the fourth Five-year plan was started in 1969.

The Eighth Plan could not take off in 1990 due to the fast changing political situation at the Centre and the years 1990-91 and 1991-92 were treated as Annual Plans. The Eighth Plan was finally launched in 1992 after the initiation of structural adjustment policies.

For the first eight Plans, the emphasis was on a growing public sector with massive investments in basic and heavy industries, but since the launch of the Ninth Plan in 1997, the emphasis on the public sector has become less pronounced and the current thinking on planning in the country, in general, is that it should increasingly be of an indicative nature.

Post -2014, the Planning Commission has been replaced by the Niti Aayog. It prepares three key documents: Vision document, 7 year strategy document and 3-year Action document.

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Outline of Various Five Year Plans

The outline of different five year plans were as follows:

First Plan (1951 - 56) Target Growth: 2.1 % Actual Growth 3.6 %

It was based on Harrod-Domar Model. Influx of refugees, severe food shortage & mounting inflation confronted the country at the onset of the first five year Plan.

The Plan focused on agriculture, price stability, power and transport.

It was a successful plan primarily because of good harvests in the last two years of the plan. Objectives of rehabilitation of refugees, food self-sufficiency & control of prices were more or less achieved.

Second Plan (1956 - 61) Target Growth: 4.5% Actual Growth: 4.3%

Simple aggregative Harrod Domar Growth Model was again used for overall projections and the strategy of resource allocation to broad sectors as agriculture & Industry was based on two & four sector Model prepared by Prof. P C Mahalanobis. (Plan is also called Mahalanobis Plan).

Second plan was conceived in an atmosphere of economic stability. It was felt agriculture could be accorded lower priority.

The Plan focused on rapid industrialization- heavy & basic industries. Advocated huge imports through foreign loans.

The Industrial Policy 1956 was based on establishment of a socialistic pattern of society as the goal of economic policy.

Acute shortage of forex led to pruning of development targets, price rise was also seen (about 30%) vis a vis decline in the earlier Plan & the 2nd FYP was only moderately successful.

Third Plan (1961 - 66) |Target Growth: 5.6% Actual Growth: 2.8%

At its conception, it was felt that Indian economy has entered a "take-off stage". Therefore, its aim was to make India a 'self-reliant' and 'self-generating' economy.

Based on the experience of first two plans (agricultural production was seen as limiting factor in India's economic development), agriculture was given top priority to support the exports and industry.

The Plan was a thorough failure in reaching the targets due to unforeseen events - Chinese aggression (1962), Indo-Pak war (1965), severe drought 1965-66. Due to conflicts, the approach during the later phase was shifted from development to defence.

Three Annual Plans (1966- 69) euphemistically described as Plan holiday.

Failure of Third Plan that of the devaluation of rupee (to boost exports) along with inflationary recession led to postponement of Fourth FYP. Three Annual Plans

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were introduced instead. Prevailing crisis in agriculture and serious food shortage necessitated the emphasis on agriculture during the Annual Plans.

During these plans a whole new agricultural strategy was implemented. It involving wide-spread distribution of high-yielding varieties of seeds, extensive use of fertilizers, exploitation of irrigation potential and soil conservation.

During the Annual Plans, the economy absorbed the shocks generated during the Third Plan

It paved the path for the planned growth ahead.

Fourth Plan (1969 - 74) Target Growth: 5.7% Actual Growth: 3.3%

Refusal of supply of essential equipment and raw materials from the allies during Indo Pak war resulted in twin objectives of " growth with stability " and "progressive achievement of self-reliance " for the Fourth Plan.

Main emphasis was on growth rate of agriculture to enable other sectors to move forward. First two years of the plan saw record production. The last three years did not measure up due to poor monsoon. Implementation of Family Planning Programmes were amongst major targets of the Plan.

Influx of Bangladeshi refugees before and after 1971 Indo-Pak war was an important issue along with price situation deteriorating to crisis proportions and the plan is considered as big failure.

Fifth Plan (1974-79) Target Growth: 4.4% Actual Growth: 4.8%

The final Draft of fifth plan was prepared and launched by D.P. Dhar in the backdrop of economic crisis arising out of run-away inflation fuelled by hike in oil prices and failure of the Govt. takeover of the wholesale trade in wheat.

It proposed to achieve two main objectives: 'removal of poverty' (Garibi Hatao) and 'attainment of self-reliance'

Promotion of high rate of growth, better distribution of income and significant growth in the domestic rate of savings were seen as key instruments

Due to high inflation, cost calculations for the Plan proved to be completely wrong and the original public sector outlay had to be revised upwards. After promulgation of emergency in 1975, the emphasis shifted to the implementation of Prime Minister's 20 Point Programme. FYP was relegated to the background and when Janta Party came to power in 1978, the Plan was terminated.

Rolling Plan (1978 - 80)

There were 2 Sixth Plans. Janta Government put forward a plan for 1978- 1983 emphasizing on employment, in contrast to Nehru Model which the Government criticized for concentration of power, widening inequality & for mounting poverty. However, the government lasted for only 2 years. Congress Government returned to power in 1980 and launched a different plan aimed at directly attacking the problem of poverty by creating conditions of an expanding economy.

Sixth Plan (1980 - 85) Target Growth: 5.2% Actual Growth: 5.7%

The Plan focused on Increase in national income, modernization of technology, ensuring continuous decrease in poverty and unemployment through schemes for transferring skills(TRYSEM) and seeds (IRDP) and providing slack season employment (NREP), controlling population explosion etc. Broadly, the Sixth Plan could be taken as a success as most of the target were realised even though during the last year (1984-85) many parts of the country faced severe famine conditions and agricultural output was less than the record output of previous year.

Seventh Plan (1985 - 90) Target Growth: 5.0% Actual Growth: 6.0%

The Plan aimed at accelerating food grain production, increasing employment opportunities & raising productivity with focus on 'food, work & productivity'.

The plan was very successful as the economy recorded 6% growth rate against the targeted 5% with the decade of 80s struggling out of the 'Hindu Rate of Growth'.

Eighth Plan (1992 - 97) Target Growth 5.6 % Actual Growth 6.8%

The Eighth plan was postponed by two years because of political uncertainty at the Centre

Worsening Balance of Payment position, rising debt burden, widening budget deficits, recession in industry and inflation were the key issues during the launch of the plan.

The plan undertook drastic policy measures to combat the bad economic situation and to undertake an annual average growth of 5.6% through introduction of fiscal & economic reforms including liberalisation under the Prime Minister ship of Shri P V Narasimha Rao.

Some of the main economic outcomes during eighth plan period were rapid economic growth (highest annual growth rate so far – 6.8 %), high growth of agriculture and allied sector, and manufacturing sector, growth in exports and imports, improvement in trade and current account deficit. High growth rate was achieved even though the share of public sector in total investment had declined considerably to about 34 %.

Ninth Plan (1997- 2002) Target Growth: 6.5% Actual Growth: 5.4%

The Plan prepared under United Front Government focussed on "Growth With Social Justice & Equality "Ninth Plan aimed to depend predominantly on the private sector – Indian as well as foreign (FDI) & State was envisaged to increasingly play the role of facilitator & increasingly involve itself with social sector viz education, health etc. and infrastructure where private sector participation was likely to be limited. It assigned priority to agriculture & rural development with a view to generate adequate productive employment and eradicate poverty.

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Tenth Plan (2002 - 2007) Target Growth 8 % Actual Growth 7.6 %

Recognizing that economic growth can't be the only objective of national plan, Tenth Plan had set 'monitorable targets' for few key indicators (11) of development besides 8 % growth target. The targets included reduction in gender gaps in literacy and wage rate, reduction in Infant & maternal mortality rates, improvement in literacy, access to potable drinking water, cleaning of major polluted rivers, etc. Governance was considered as factor of development & agriculture was declared as prime moving force of the economy. States role in planning was to be increased with greater involvement of Panchayati Raj Institutions. State wise break up of targets for growth and social development sought to achieve balanced development of all states.

Eleventh Plan (2007 - 2012) Target Growth 9 % Actual Growth 8%

Eleventh Plan was aimed "Towards Faster & More Inclusive Growth "after UPA rode back to power on the plank of helping Aam Aadmi (common man).

India had emerged as one of the fastest growing economies by the end of the Tenth Plan. The savings and investment rates had increased, industrial sector had responded well to face competition in the global economy and foreign investors were keen to invest in India. But the growth was not perceived as sufficiently inclusive for many groups, specially SCs, STs & minorities as borne out by data on several dimensions like poverty, malnutrition, mortality, current daily employment etc.

The broad vision for 11th Plan included several inter related components like rapid growth reducing poverty & creating employment opportunities , access to essential services in health & education, especially for the poor, extension if employment opportunities using National Rural Employment Guarantee Programme , environmental sustainability , reduction of gender inequality etc. Accordingly various targets were laid down like reduction in unemployment(to less than 5 % among educated youth) & headcount ratio of poverty (by 10 %), reduction in dropout rates , gender gap in literacy , infant mortality , total fertility , malnutrition in age group of 0-3 (to half its present level), improvement in sex ratio, forest & tree cover, air quality in major cities, , ensuring electricity connection to all villages & BPL households (by 2009) & reliable power by end of 11th Plan , all weather road connection to habitations with population 1000& above (500 in hilly areas) by 2009, connecting every village by telephone & providing broad band connectivity to all villages by 2012

The Eleventh Plan started well with the first year achieving a growth rate of 9.3 per cent, however the growth decelerated to 6.7 per cent rate in 2008-09 following the global financial crisis. The economy recovered substantially to register growth rates of 8.6 per cent and 9.3 per cent in 2009-10 and 2010-11 respectively. However, the second bout of global slowdown in 2011 due to the sovereign debt crisis in Europe coupled with domestic factors such as tight monetary policy and

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supply side bottlenecks, resulted in deceleration of growth to 6.2 per cent in 2011-12. Consequently, the average annual growth rate of Gross Domestic Product (GDP) achieved during the Eleventh Plan was 8 per cent, which was lower than the target but better than the Tenth Plan achievement. Since the period saw two global crises - one in 2008 and another in 2011 – the 8 per cent growth may be termed as satisfactory. The realized GDP growth rate for the agriculture, industry and services sector during the 11th Plan period is estimated at 3.7 per cent, 7.2 per cent and 9.7 per cent against the growth target of 4 per cent, 10-11 per cent and 9-11 per cent respectively. The Eleventh Plan set a target of 34.8 per cent for domestic savings and 36.7 per cent for investment after experiencing a rising level of domestic savings as well as investment and especially after emergence of structural break during the Tenth Plan period. However, the domestic savings and investment averaged 33.5 per cent and 36.1 per cent of GDP at market prices respectively in the Eleventh Plan which is below the target but not very far. Based on the latest estimates of poverty released by the Planning Commission, poverty in the country has declined by 1.5 percentage points per year between 2004-05 and 2009-10.The rate of decline during the period 2004-05 to 2009-10 is twice the rate of decline witnessed during the period 1993-94 to 2004-05. Though the new poverty count based on Tendulkar Formula has been subject of controversy, it is believed by the Committee that whether we use the old method or the new, the decline in percentage of population below poverty line is almost same. On the fiscal front, the expansionary measures taken by the government to counter the effect of global slowdown led to increase in key indicators through 2009-10 with some moderation thereafter.

The issue of Price Stability remained resonating for more than half of the Plan period. Inability to pass on burden on costlier imported oil prices might have constrained the supply of investible funds in the government's hand causing the 11th Plan to perform at the levels below its target.

Twelfth Five Year Plan (2012-17)

The Twelfth Plan commenced at a time when the global economy was going through a second financial crisis, precipitated by the sovereign debt problems of the Eurozone which erupted in the last year of the Eleventh Plan. The crisis affected all countries including India. Our growth slowed down to 6.2 percent in 2011-12 and the deceleration continued into the first year of the Twelfth Plan, when the economy is estimated to have grown by only 5 percent. The Twelfth Plan therefore emphasizes that our first priority must be to bring the economy back to rapid growth while ensuring that the growth is both inclusive and sustainable. The broad vision and aspirations which the Twelfth Plan seeks to fulfil were reflected in the subtitle: 'Faster, Sustainable, and More Inclusive Growth'. Inclusiveness is to be achieved through poverty reduction, promoting group equality and regional balance, reducing inequality, empowering people etc. whereas sustainability includes ensuring environmental sustainability, development of human capital through improved health,

education, skill development, nutrition, information technology and development of institutional capabilities, infrastructure like power telecommunication, roads, transport etc.

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Apart from the global slowdown, the domestic economy has also run up against several internal constraints. Macro-economic imbalances have surfaced following the fiscal expansion undertaken after 2008 to give a fiscal stimulus to the economy. Inflationary pressures have built up. Major investment projects in energy and transport have slowed down because of a variety of implementation problems. Some changes in tax treatment in the 2012–13 have caused uncertainty among investors. These developments have produced a reduction in the rate of investment, and a slowing down of economic growth.

The policy challenge in the Twelfth Plan was, therefore, two-fold. The immediate challenge was to reverse the observed deceleration in growth by reviving investment as quickly as possible. This called for urgent action to tackle implementation constraints in infrastructure which are holding up large projects, combined with action to deal with tax related issues which have created uncertainty in the investment climate. From a longer term perspective, the Plan put in place policies that could leverage the many strengths of the economy to bring it back to its real Growth potential.

Immediate priority is to revive the investor sentiment along with next short term action of removing the impediments to implementation of projects in infrastructure, especially in the area of energy which would require addressing the issue of fuel supply to power stations, financial problems of discoms and clarity in terms of New Exploration Licensing Policy (NELP).

Although planning should cover both the activities of the government and those of the private sector, a great deal of the public debate on planning in India takes place around the size of the public sector plan. The Twelfth Plan laid out an ambitious set of Government programmes, which help to achieve the objective of rapid and inclusive growth. In view of the scarcity of resources, it is essential to take bold steps to improve the efficiency of public expenditure through plan programmes. Need for fiscal correction viz. tax reforms like GST, reduction of subsidies as percent of GDP while still allowing for targeted subsidies that advance the cause of inclusiveness and managing the current account deficit were other chief concerns.

Achieving sustained growth would require long term increase in investment and savings rate. Bringing the economy back to 9 per cent growth by the end of the Twelfth Plan required fixed investment rate to rise to 35 per cent of GDP by the end of the Plan period. This required action to revive private investment, including private corporate investment, and also action to stimulate public investment, especially in key areas of infrastructure especially, energy, transport, water supply and water resource management. Reversal of the combined deterioration in government and corporate savings were a key element in the strategy.

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Monitorable Targets of the Plan for Health

- Reduce IMR to 25 and MMR to 100 per 1,000 live births, and improve Child Sex Ratio (0–6 years) to 950 by the end of the Twelfth FYP.
- Reduce Total Fertility Rate to 2.1 by the end of Twelfth FYP.
- Reduce under-nutrition among children aged 0–3 years to half of the NFHS-3 levels by the end of Twelfth FYP.
- At the end of the plan period, the IMR was reduced to 37, MMR was 167 and child sex ratio was 919. The TFR was 2.3 and under nutrition was 35.7% till 2015-16.

Framework for Health in 12th Plan

A Renewed Commitment to Public Health: Health, a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, is a precondition to the realization of human potential and for attainment of happiness. Thus, health is both a social and an economic good. The Directive Principles of State Policy in the Constitution of India mandate 'improvement of public health' as one of the primary duties of the State. The Central and State Governments have been taking proactive steps to promote health of the people by creating a network of public health care facilities, which provide free medical services, and also proactively control the spread of diseases. Moreover, the Prime Minister in his Independence Day speech (2011) stressed upon the need to provide access to improved health services to all. Calling for the 12th Plan to be specially focused on health, the Prime Minister promised that funds would not be a constraint in the important areas of education and health.

Review of the health system during the previous Plan: A health system is the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. The 11th Plan had set six health outcome indicators as time-bound 'goals'. These included lowering maternal and infant mortality, malnutrition among children, anaemia among women and girls, and fertility, and raising the child sex ratio. Though, there has been progress on all these fronts, except child sex ratio, the goals have not been fully met. Low public spending on health (1% of GDP), high out-of-pocket payments (71%) (Table-5.1) leading to impoverishment, high levels of anaemia (56% among ever-married women aged 15-45 years) reflect in high levels of malnutrition among children (wasting 22.9%, stunting 44.9%), high infant mortality (47/1000 live births) and maternal mortality (212 per 1 lakh live births). India trails in health outcomes behind its South Asian neighbours like Sri Lanka and Bangladesh, which have a comparable per capita income. Large variations within the country suggest that the health status of disadvantaged groups is even worse. Equally worrying is the growing reliance on private providers, which currently service 78% of outpatients and 60% of in-patients. For those who cannot afford private services, illness translates into high out-of-pocket expenditure as a

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proportion of total household expenditure, reaching catastrophic proportions at times (i.e. equal to or greater than 40% of a household's non-subsistence income). With a rising trend in non-communicable diseases, even as we try to conquer conventional, communicable diseases, India is facing a dual burden of disease, presenting a difficult challenge to the health system. Meanwhile, the strategies for provision of inputs and creation of health infrastructure under the National Rural Health Mission (NRHM) have not yet fully translated into assured health care services for the people.

Identifying Structural Problems: The health care system in the country suffers from inadequate funding. There are several structural problems too, like, the lack of integration between disease control and other programmes in the social sector, sub-optimal use of traditional systems of medicines, weak regulatory systems for drugs as well as for medical practice, and poor capacity in public health management. A sound health system also requires the active participation of communities in preventive and promotive health care, on which the progress has been uneven.

Table 13.1 *Health Expenditure in India: 2002-2009*

Year	2001-02		2004-05		2008-09	
	% of Total	% of GDP	% of Total	% of GDP	% of Total	% of GDP
Public Funds (Rs. Crores)	**21439**		**26313**		**58681**	
	20	**0.9**	**20**	**0.8**	**27**	**1.1**
Central Government	6719		9067			
	6	**0.3**	**7**	**0.3**		
State Government	13271		16017			
	13	**0.6**	**12**	**0.5**		
Local Bodies	1450		1229			
	1	**0.1**	**1**	**0.0**		
Private Funds (Rs. Crores)	**81710**		**104414**		**157394**	
	77	**3.6**	**78**	**3.3**	**72**	**3.0**
Households	76094		95154			
	72	**3.3**	**71**	**3.0**		
External Flows (Rs. Crores)	**2485**		**3050**		**3702**	
	2	**0.1**	**2**	**0.1**	**2**	**0.1**
Total Health Expenditure (Cr.)	**105634**		**133776**		**219777**	
	100	**4.6**	**100**	**4.2**	**100**	**4.1**
Per Capita Health Expenditure (Rs.)	**1016**		**1228**		**1904**	

Source: National Health Accounts

Goals for Health Systems: Any health system should set certain goals for itself, which may include a broad commitment to improving the health of the population, keeping principles of equity and democratic participation in mind. Such goals would, in turn, ensure that the guiding health policy is responsive to the expectations of the population, that it has an equitable position on financial contributions, and that it has strategies for both preventive and curative health care. Furthermore, only having fixed goals and a matching policy may not be enough. Progress towards the goals would eventually depend on how the three vital functions, namely, provision of health care services, its financing, and stewardship of inter-sectoral policies that may have a bearing on health are actually carried out. The processes that mould delivery systems, i.e. how democratic or responsive to local needs they are, would

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also have a bearing on the vital functions. There are also other dimensions that contribute to the overarching goals of health care system, which include 'quality', 'efficiency', 'acceptability' and 'equity'. Responsiveness of health systems is assessed by WHO on users' perception of services on seven parameters, namely choice, communication, confidentiality, dignity, basic amenities, prompt attention and autonomy. Finally, while the goals of the health system are broad and more comprehensive, they may be summarily reflected in its health outcome indicators.

National Health Outcome Goals for the 12th Plan: It was expected that the health system for the 12th Plan should address the objectives listed above and aim to build a collaborative environment for their realization. It should prioritize the making of the system responsive to the needs of citizens, and the attainment of financial protection for the health care of households. More specifically, the national health outcome goals, which are meant to reflect the broader commitments during the 12th Plan should be the following:

1. Reduction of Maternal Mortality Ratio (MMR)
2. Reduction of Infant Mortality Rate (IMR)
3. Reduction of Total Fertility Rate (TFR)
4. Prevention and reduction of underweight children under 3 years
5. Prevention and reduction of anaemia among women aged 15-49 years
6. Raising child sex ratio in the 0-6 year age group from 914 to 935
7. Prevention and reduction of burden of diseases – Communicable, Non Communicable (including mental illnesses) and injuries
8. Reduction of households' out-of-pocket expenditure from 71% to 50% of total health care expenditure

Overarching Principles and strategies for the 12th Plan: The Parliamentary Standing Committees of the last five years, as well as the High Level Expert Group (HLEG) on Universal Health Coverage, and the 12th Plan Approach Paper have already provided various recommendations for improving health care delivery systems. In light of these recommendations, as also the experience of implementation of health programmes in the country and globally, the 12th Plan should adopt a systemic approach to Health.

Structure of the Steering Committee Report: The Planning Commission appointed seven Working Groups on subjects that coincided with the existing distribution of work at 16 Ministries (NRHM, Tertiary Care Institutions, Disease Burden - Communicable and Non Communicable Diseases, Drugs and Food Regulation, Health Research, AIDS Control and AYUSH) to deliberate on and recommend the course of action for their respective thematics. The reports of the seven Working Groups were summarized and analyzed in the Health Division, and used as inputs for a round of brainstorming of the Steering Committee on ten freshly identified cross-cutting themes, which were more closely aligned to the spirit of the Prime Minister's call for improved health services.

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These were:

- National Health Programmes
- Health Information Systems
- Convergence with other Social Sector Programmes
- Public Health Management
- Strengthening Tertiary Care
- Human Resources for Health
- Regulation of Food, Drugs, Medical Practice and Public Health
- Promoting Health Research
- AYUSH – Integration in Research, Teaching and Health Care
- Inclusive Agenda

The Niti Aayog's 'Appraisal Document of Twelfth Five Year Plan 2012-17' noted that:

> Despite significant improvements in health indicators and achievement of Millennium Development Goals to a large extent, the targets of the Twelfth Plan were largely missed, especially with respect to maternal and child health. The large supply-side gaps (for which data is available) that may be partly associated with these outcomes is the lack of adequate health facilities (20 per cent and 23 per cent shortfall of sub- centres and PHCs respectively) and health workers (particularly shortage of specialists (81.19 per cent) to staff the facilities; gaps which must be filled up on priority… 52.73 per cent of the envisaged total 12th Plan Outlay was actually allocated during the period, of that utilization (AE) is about 84.01 per cent. The utilization as per percentage of 12th Plan Outlay is about 44.3 per cent.

The Niti Aayog has come up with a document 'Strategy for New India @ 75' which has identified 41 different areas that require either a sharper focus on implementing the flagship schemes already in place or a new design and initiative to achieve India's true potential. Let's briefly look at the schemes pertaining to health policy.

- **Public Health Management and Action**

  Objectives:

  - To revamp radically the public and preventive health system in the nation through the following strategic interventions:
  - Mobilize public health action through an integrated, inter-sectoral and pan-stakeholder approach, targeted at communities and individuals as well as grassroots organizations, aimed at creating an unprecedented people-led movement for health and wellness.
  - Operationalize vital enablers - a) public health and management cadre, b) public health agency with capacitated supporting institutions.

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- **Comprehensive Primary Health Care**

  Objectives:

  - Under Ayushman Bharat, scale-up a new vision for comprehensive primary health care across the country, built on the platform of health and wellness centres (HWCs).
  - Provide quality ambulatory services for an inclusive package of diagnostic, curative, rehabilitative and palliative care, close to the people.
  - Deliver preventive and promotion services, and action on the ground to tackle determinants of ill health locally.
  - Create a mass movement for Healthy India (Swasth Bharat Jan Andolan).
- **Human Resources for Health**

  Objectives:

  - Achieve a doctor-population ratio of at least 1:1400 (WHO norm 1:1000) and nurse population ratio of at least 1:500 (WHO norm 1:400) by 2022-23.
  - Ensure availability of paramedics and doctors as per Indian Public Health Standard (IPHS) norms in high priority districts by 2020 (National Health Policy, 2017).
  - Deploy mid-level providers (MLPs) to manage the primary healthcare system.
  - Generate at least 1.5 million jobs in the public health sector by 2022-23, a large number of which will employ women.
- **Universal Health Coverage**

  Objectives:

  - On the strong platform of Pradhan Mantri - Jan Arogya Yojana (PM-JAY), attain a coverage of at least 75 per cent of the population with publicly financed health insurance (covering most secondary and tertiary care procedures) by 2022-23.
  - Reduce by 50 per cent the proportion of households facing catastrophic health expenditure from the current levels.
- **Nutrition**

  Objectives:

  - Under POSHAN Abhiyaan, achieve the following outcomes by 2022-23, compared to the baseline of 2015-16 (National Family Health Survey-4)
  - Reduce the prevalence of stunting among children to 25 per cent or less.

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- Reduce the prevalence of underweight in children (0-6 years) to 25 per cent or less.
- Reduce the prevalence of anaemia among young children (6-59 months) to 43 per cent or less.
- Reduce the prevalence of anaemia among adolescent girls and women (15-49 years) to 38 per cent or less.

The document also says that the 'Public funding on health should be increased to at least 2.5 per cent of GDP as envisaged in the National Health Policy, 2017.

Check Your Progress

1. Why could the Eighth Plan not take off?
2. What were some of the main economic outcomes during the Eighth Plan period?
3. What did the targets of the Eleventh Plan include?
4. State the structural problems in the health care system.
5. On which parameters is the responsiveness of health systems assessed by WHO?
6. List two objectives of comprehensive primary health care.

13.3 NATIONAL HEALTH POLICIES

As per the World Health Organization (WHO), a health policy refers to decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people'. Health policies are of various types such as global health policy, public health policy, national health policy of a country, healthcare services policy, mental health policy, and so on.

As stated above, every health policy aims as achieving specific goals and for a National Health Policy these goals revolves around the following broad objectives:

- Improvement in the health of the population
- Enhanced responsiveness of the health system as per the expectations of the population
- Fairness in financing

The aim is to ensure that poor should not pay a higher share of their expenditure on health than the rich, and the whole population should be protected against catastrophic financial losses related to ill health.

Need of Health Policy

Despite the major advances in medical science and huge expenditure in health sector, a majority of the population is unable to achieve their full health potential, this affects the quality and duration on their life span. It also affects their ability to be productive members of the society. Poor health of a population also has financial implications- loss of productivity and the cost of treating diseases. All of this affects the society at large.

Health is affected by an array of factors that operate on multiple levels and throughout a person's lifetime. Although it is important for a society to have access to quality healthcare, prevention is the key. Disease prevention and health promotion require addressing a much broader set of factors and health policies that shape health-related behaviours of a population at large. Efforts to improve early detection and treatment of diseases through improved access to high-quality medical care must be complemented by approaches that address the underlying or root causes of disease, this can only be made possible by implementing a health policy that caters to the real health needs of the population. The underlying causes include the factors that shape the conditions in which people are born, grow, live, work, and age, and the policies that affect them. Health policy and planning decisions have powerful implications for individual behaviours and public health.

National Health Policy, 2017

In India the first National Health Policy was launched in 1983 and the same was revised in the year 2002. These policies have served well in guiding the approach for the health sector in various five-year plans. The latest Health Policy was drafted in the year 2017. There are four major changes in the current health policy. First, the health priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of non- communicable diseases and some infectious diseases. The second important change is the emergence of a robust healthcare industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to healthcare costs, which are presently estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity.

The primary objective of the National Health Policy, 2017, is to educate, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions- investments in health, organization of healthcare services, prevention of diseases and promotion of good health through cross sectoral actions, access to technologies, developing human resources, encouraging medical pluralism,

building knowledge base, developing better financial protection strategies, strengthening regulation and health assurance.

Goal

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The goal of the policy is to attain the highest possible level of health and well-being for all age groups through a preventive and promotive healthcare orientation in all developmental policies. It also aims at universal access to good quality healthcare services without anyone having to face financial hardship as a consequence. This can be achieved through increasing access, improving quality and lowering the cost of healthcare delivery.

The policy has a list of Sustainable Development Goals (SDGs) that are time bound quantitative goals aligned to ongoing national efforts as well as the global strategic directions.

Key Policy Principles

The key policy principles of the National Health Policy are:

I. **Professionalism, Integrity and Ethics:** The health policy commits itself to the highest professional standards, integrity and ethics to be maintained in the entire system of healthcare delivery in India, supported by a credible, transparent and responsible regulatory environment.

II. **Equity:** Reducing inequity would mean taking action to reach the poorest. It would mean minimising disparity on account of gender, poverty, caste, disability, other forms of social exclusion and geographical barriers. It would imply greater investments and financial protection for the poor who suffer the largest burden of disease.

III. **Affordability:** As cost of healthcare increases, affordability, as distinct from equity, requires emphasis. Health expenditure exceeding 10% of the total monthly expenditure or 40% of the monthly non-food consumption expenditure, are unacceptable and are termed as catastrophic.

IV. **Universality:** This means prevention of exclusions on social, economic or on grounds of current health status. To implement this, systems and services are to be designed to cater to the entire population- including special groups.

V. **Patient Centred & Quality of Care:** The objective is to provide gender sensitive, effective, safe, and convenient healthcare services with dignity and confidentiality. There is need to evolve and spread standards and guidelines for all levels of facilities and a system to ensure that the quality of healthcare is not compromised.

VI. **Accountability:** Financial and performance accountability, transparency in decision making, and elimination of corruption in healthcare systems, both in public and private.

VII. **Inclusive Partnerships:** A multi stakeholder approach with partnership & participation of all non- health ministries and communities. This approach would include partnerships with academic institutions, not for profit agencies, and healthcare industry as well.

VIII. **Pluralism:** Patients may choose to have access to AYUSH care providers based on documented and validated local, home and community based practices. These systems, would also have Government support in research and supervision to develop and enrich their contribution to meeting the national health goals and objectives through integrative practices.

IX. **Decentralization:** Decentralization of decision making to make it more practical. Community participation in health planning processes, to be promoted side by side.

X. **Dynamism and Adaptiveness:** constantly improving organisations of healthcare based on new knowledge and learning from the communities from national and international knowledge partners.

Objectives of National Health Policy

To improve the health status of the country through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality.

I. Progressively achieve Universal Health Coverage

A. Assuring availability of free, comprehensive primary healthcare services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population. The Policy also envisages optimum use of existing manpower and infrastructure as available in the health sector. It also advocates collaboration with non-government sector on pro-bono basis for delivery of healthcare services linked to a health card, to enable every family to have access to a doctor of their choice from amongst those volunteering their services.

B. Ensuring improved access and affordability, of quality secondary and tertiary care services through a combination of public hospitals and well measured strategic purchasing of services in healthcare deficit areas, from private care providers, especially the not-for profit providers

C. Achieving a significant reduction in out of pocket expenditure due to healthcare costs and achieving reduction in proportion of households experiencing catastrophic health expenditures and consequent impoverishment.

II. Reinforcing trust in Public Health Care System

Strengthening the trust of the common man in public healthcare system by making it predictable, efficient, patient centric, affordable and effective, with a comprehensive package of services and products that meet immediate healthcare needs of most people.

III. Align the growth of private healthcare sector with public health goals

Influence the operation and growth of the private healthcare sector and medical technologies to ensure alignment with public health goals. Enable private sector contribution to making healthcare systems more effective, efficient, rational, safe, affordable and ethical. Strategic purchasing by the Government to fill critical gaps in public health facilities will create a demand for private healthcare sector, in alignment with the public health goals.

Specific Quantitative Goals and Objectives

The indicative, quantitative goals and objectives are outlined under three broad components viz. (I) health status and programme impact, (II) health systems performance and (III) health system strengthening. These goals and objectives are aligned to achieve sustainable development in health sector in keeping with the policy thrust.

I. Health Status and Programme Impact

Life Expectancy and healthy life

a. Increase Life Expectancy at birth from 67.5 to 70 by 2025.
b. Establish regular tracking of Disability Adjusted Life Years (DALY) Index as a measure of burden of disease and its trends by major categories by 2022.
c. Reduction of TFR to 2.1 at national and sub-national level by 2025.

Mortality by Age and/ or cause

a. Reduce Under Five Mortality to 23 by 2025 and MMR from current levels to 100 by 2020.
b. Reduce infant mortality rate to 28 by 2019.
c. Reduce neo-natal mortality to 16 and still birth rate to "single digit" by 2025.

Reduction of disease prevalence/ incidence

a. Achieve global target of 2020 which is also termed as target of 90:90:90, for HIV/AIDS i.e,- 90% of all people living with HIV know their HIV status, - 90% of all people diagnosed with HIV infection receive sustained

antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.

b. Achieve and maintain elimination status of Leprosy by 2018, Kala-Azar by 2017 and Lymphatic Filariasis in endemic pockets by 2017.

c. To achieve and maintain a cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.

d. To reduce the prevalence of blindness to 0.25/1000 by 2025 and disease burden by one third from current levels.

e. To reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025.

II. Health Systems Performance

Coverage of Health Services

a. Increase utilization of public health facilities by 50% from current levels by 2025.

b. Antenatal care coverage to be sustained above 90% and skilled attendance at birth above 90% by 2025.

c. More than 90% of the newborns are fully immunized by one year of age by 2025.

d. Meet need of family planning above 90% at national and sub national level by 2025.

e. 80%of known hypertensive and diabetic individuals at house hold level maintain, controlled disease status by 2025.

Cross-Sectoral goals related to health

a. Relative reduction in prevalence of current tobacco use by 15% by 2020 and 30% by 2025.

b. Reduction of 40% in prevalence of stunting of under-five children by 2025.

c. Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission).

d. Reduction of occupational injury by half from current levels of 334 per lakh agricultural workers by 2020.

e. National/ State level tracking of selected health behaviour.

III. Health Systems strengthening

Health finance

a. Increase health expenditure by Government as a percentage of GDP from the existing 1.15% to 2.5 % by 2025.

b. Increase State sector health spending to > 8% of their budget by 2020.

c. Decrease in proportion of households facing catastrophic expenditure from the current levels by 25%, by 2025.

Health Infrastructure and Human Resource

a. Ensure availability of paramedics and doctors as per Indian Public Health Standard (IPHS) norm in high priority districts by 2020.

b. Increase community health volunteers to population ratio as per IPHS norm, in high priority districts by 2025.

c. Establish primary and secondary care facility as per norms in high priority districts (population as well as time to reach norms) by 2025.

Health Management Information

a. Ensure district-level electronic database of information on health system components by 2020.

b. Strengthen the health surveillance system and establish registries for diseases of public health importance by 2020.

c. Establish federated integrated health information architecture, Health Information Exchanges and National Health Information Network by 2025.

Policy Thrust

Ensuring Adequate Investment

The policy proposes a potentially achievable target of raising public health expenditure to 2.5% of the GDP in a time bound manner. It envisages that the resource allocation to States will be linked with State development indicators, absorptive capacity and financial indicators. The States would be incentivized for incremental State resources for public health expenditure. General taxation will remain the predominant means for financing care. The Government could consider imposing taxes on specific commodities- such as the taxes on tobacco, alcohol and foods having negative impact on health, taxes on extractive industries and pollution cess. Funds available under Corporate Social Responsibility would also be leveraged for well-focused programmes aiming to address health goals.

Preventive and Promotive Health

The policy articulates to institutionalize inter-sectoral coordination at national and sub-national levels to optimize health outcomes, through constitution of bodies that have representation from relevant non-health ministries. This is in line with the emergent international "Health in All" approach as complement to Health for All. The policy prerequisite is for an empowered public health cadre to address social determinants of health effectively, by enforcing regulatory provisions.

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The policy identifies coordinated action on seven priority areas for improving the environment for health:

- The Swachh Bharat Abhiyan
- Balanced, healthy diets and regular exercises.
- Addressing tobacco, alcohol and substance abuse
- Yatri Suraksha – preventing deaths due to rail and road traffic accidents o Nirbhaya Nari –action against gender violence
- Reduced stress and improved safety in the work place
- Reducing indoor and outdoor air pollution

The policy also articulates the need for the development of strategies and institutional mechanisms in each of these seven areas, to create Swasth Nagrik Abhiyan –a social movement for health. It recommends setting indicators, their targets as also mechanisms for achievement in each of these areas.

The policy recognizes and builds upon preventive and promotive care as an under-recognized reality that has a two-way continuity with curative care, provided by health agencies at same or at higher levels. The policy recommends an expansion of scope of interventions to include early detection and response to early childhood development delays and disability, adolescent and sexual health education, behaviour change with respect to tobacco and alcohol use, screening, counselling for primary prevention and secondary prevention from common chronic illness –both communicable and non-communicable diseases. Additionally, the policy focus is on extending coverage as also quality of the existing package of services. The policy recognizes the need to frame and adhere to health screening guidelines across age groups. Zoonotic diseases like rabies need to be addressed through concerted and coordinated action, at the national front and through strengthening of the National Rabies Control Programme.

The policy lays greater emphasis on investment and action in school health- by incorporating health education as part of the curriculum, promoting hygiene and safe health practices within the school environs and by acting as a site of primary healthcare. Promotion of healthy living and prevention strategies from AYUSH systems and Yoga at the work-place, in the schools and in the community would also be an important form of health promotion that has a special appeal and acceptability in the Indian context.

Recognizing the risks arising from physical, chemical, and other workplace hazards, the policy advocates for providing greater focus on occupational health. Work-sites and institutions would be encouraged and monitored to ensure safe health practices and accident prevention, besides providing preventive and promotive healthcare services.

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ASHA will also be supported by other frontline workers like health workers (male/female) to undertake primary prevention for non-communicable diseases. They would also provide community or home based palliative care and mental health services through health promotion activities. These workers would get support from local self-government and the Village Health Sanitation and Nutrition Committee (VHSNC).

In order to build community support and offer good healthcare to the vulnerable sections of the society like the marginalized, the socially excluded, the poor, the old and the disabled, the policy recommends strengthening the VHSNCs and its equivalent in the urban areas.

'Health Impact Assessment' of existing and emerging policies, of key non-health departments that directly or indirectly impact health would be taken up.

Organization of Public Health Care Delivery

The policy proposes seven key policy shifts in organizing healthcare services

- In primary care–from selective care to assured comprehensive care with link ages to referral hospitals
- In secondary and tertiary care – from an input oriented to an output based strategic purchasing in public hospitals – from user fees & cost recovery to assured free drugs, diagnostic and emergency services to all
- In infrastructure and human resource development – from normative approach to targeted approach to reach under-serviced areas
- In urban health – from token interventions to on-scale assured interventions, to organise Primary Health Care delivery and referral support for urban poor. Collaboration with other sectors to address wider determinants of urban health is advocated.
- In National Health Programmes–integration with health systems for programme effectiveness and in turn contributing to strengthening of health systems for efficiency.
- In AYUSH services – from stand-alone to a three dimensional mainstreaming

Free primary care provision by the public sector, supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and from non-government sector to fill critical gaps would be the main strategy of assuring healthcare services. The policy envisages strategic purchase of secondary and tertiary care services as a short term measure. Strategic purchasing refers to the Government acting as a single payer. The order of preference for strategic purchase would be public sector hospitals followed by not-for-profit private sector and then commercial private sector in underserved areas, based on availability of services of acceptable and defined quality criteria.

In the long run, the policy envisages to have fully equipped and functional public sector hospitals in these areas to meet secondary and tertiary healthcare needs of population, especially the poorest and marginalized. Public facilities would remain the focal point in the healthcare delivery system and services in the public health facilities would be expanded from current levels. The policy recognizes the special health needs of tribal and socially vulnerable population groups and recommends situation specific measures in provisioning and delivery of services. The policy advocates enhanced outreach of public healthcare through Mobile Medical Units (MMUs), etc. Tribal population in the country is over 100 million (Census 2011), and hence deserves special attention keeping in mind their geographical and infrastructural challenges. Keeping in view the high cost involved in provisioning and managing orphan diseases, the policy encourages active engagement with non- government sector for addressing the situation. In order to provide access and financial protection at secondary and tertiary care levels, the policy proposes free drugs, free diagnostics and free emergency care services in all public hospitals. To address the growing challenges of urban health, the policy advocates scaling up National Urban Health Mission (NUHM) to cover the entire urban population within the next five years with sustained financing.

For effectively handling medical disasters and health security, the policy recommends that the public healthcare system retain a certain excess capacity in terms of health infrastructure, human resources, and technology which can be mobilized in times of crisis.

In order to leverage the pluralistic healthcare legacy, the policy recommends mainstreaming the different health systems. This would involve increasing the validation, evidence and research of the different healthcare systems as a part of the common pool of knowledge. It would also involve providing access and informed choice to the patients, providing an enabling environment for practice of different systems of medicine, an enabling regulatory framework and encouraging cross referrals across these systems.

Primary Care Services and Continuity of Care:

This policy denotes important change from very selective to comprehensive primary healthcare package which includes geriatric (relating to old people) healthcare, palliative care and rehabilitative care services. The facilities which start providing the larger package of comprehensive primary healthcare will be called 'Health and Wellness Centres'. Primary care must be assured. To make this a reality, every family would have a health card that links them to primary care facility and be eligible for a defined package of services anywhere in the country. The policy recommends that health centres be established on geographical norms apart from population norms. To provide comprehensive care, the policy recommends a matching human resources development strategy, effective logistics support system and referral backup. This would also necessitate upgradation of

the existing sub-centres and reorienting PHCs to provide comprehensive set of preventive, promotive, curative and rehabilitative services. It would entail providing access to assured AYUSH healthcare services, as well as support documentation and validation of local home and community based practices. The policy also advocates for research and validation of tribal medicines. Leveraging the potential of digital health for two way systemic linkages between the various levels of care viz., primary, secondary and tertiary, would ensure continuity of care. The policy advocates that the public health system would put in place a gatekeeping mechanism at primary level in a phased manner, accompanied by an effective feedback and follow-up mechanism.

Secondary Care Services

The policy aspires to provide at the district level most of the secondary care which is currently provided at a medical college hospital. Basic secondary care services, such as caesarean section and neonatal care would be made available at the least at sub-divisional level in a cluster of few blocks. To achieve this, the policy aims:

- To have at least two beds per thousand population distributed in such a way that it is accessible within golden hour rule. This implies an efficient emergency transport system. The policy also aims that ten categories of what are currently specialist skills be available within the district. Additionally four or at least five of these specialist skill categories be available at sub-district levels. This may be achieved by strengthening the district hospital and a well-chosen, well located set of sub-district hospitals.
- Resource allocation that is responsive to quantity, diversity and quality of caseloads provided.
- Purchasing care after due diligence from non-Government hospitals as a short term strategy till public systems are strengthened.

Policy proposes a responsive and strong regulatory framework to guide purchasing of care from non-government sector so that challenges of quality of care, cost escalations and impediments to equity are addressed effectively.

In order to develop the secondary care sector, comprehensive facility development and obligations with regard to human resources, especially specialists' needs are to be prioritized. To this end the policy recommends a scheme to develop human resources and specialist skills.

Access to blood and blood safety has been a major concern in district healthcare services. This policy affirms in expanding the network of blood banks across the country to ensure improved access to safe blood.

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Re-Orienting Public Hospitals

Public hospitals have to be viewed as part of tax financed single payer healthcare system, where the care is pre-paid and cost efficient. This outlook implies that quality of care would be imperative and the public hospitals and facilities would undergo periodic measurements and certification of level of quality. The policy endorses that the public hospitals would provide universal access to a progressively wide array of free drugs and diagnostics with suitable leeway to the States to suit their context. The policy seeks to eliminate the risks of inappropriate treatment by maintaining adequate standards of diagnosis and treatment. The policy recognizes the need for an information system with comprehensive data on availability and utilization of services not only in public hospitals but also in non-government sector hospitals. State public health systems should be able to provide all emergency health services other than services covered under national health programmes.

Closing Infrastructure and Human Resources/Skill Gaps

The policy duly acknowledges the roadmap of the 12th Five Year Plan for managing human resources for health. The policy initiatives aim for measurable improvements in quality of care. Districts and blocks which have wider gaps for development of infrastructure and deployment of additional human resources would receive focus. Financing for additional infrastructure or human resources would be based on needs of outpatient and inpatient attendance and utilisation of key services in a measurable manner.

Urban Health Care

National health policy priorities addressing the primary healthcare needs of the urban population with special focus on poor populations living in listed and unlisted slums, other vulnerable populations such as homeless, rag-pickers, street children, rickshaw pullers, construction workers, sex workers and temporary migrants. Policy would also prioritize the utilization of AYUSH personnel in urban healthcare. Given the large presence of private sector in urban areas, policy recommends exploring the possibilities of developing sustainable models of partnership with 'for profit' and 'not for profit' sector for urban healthcare delivery. An important focus area of the urban health policy will be achieving convergence among the wider determinants of health – air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress. These dimensions are also important components of smart cities. Healthcare needs of the people living in the peri-urban areas would also be addressed under the NUHM. Further, Non-Communicable Diseases (NCDs) like hyper tension, diabetes which are predominant in the urban areas would be addressed under NUHM, through planned early detection. Better secondary prevention would also be an integral part of the urban health strategy. Improved

health seeking behaviour, influenced through capacity building of the community based organisations & establishment of an appropriate referral mechanism, would also be important components of this strategy.

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Check Your Progress

7. What can an explicit health policy achieve?
8. What is the goal of the National Health Policy, 2017?
9. What does the National Health Policy propose?
10. What would be the order of preference for strategic purchase?

13.4 PUBLIC HEALTH SYSTEMS IN INDIA: CENTER, STATE, DISTRICT & VILLAGE LEVEL

As per the recommendations of Bhore Committee 1946, provision of health care services was meant to be in an integrated manner, as a package, as explained above. Comprehensive health is not provided by the health department alone but in combination with health related departments such as agriculture, irrigation, fisheries, etc.

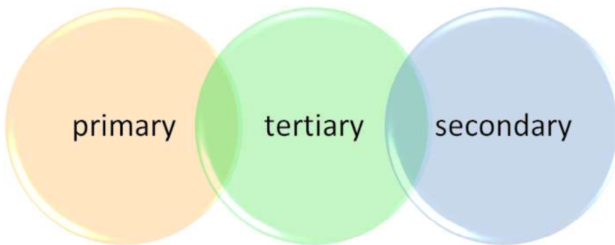


Fig. 13.1 *Levels of Health Care*

Levels of Health Care

Let us analyze the different levels of health care.

1. Primary Level of Health Care

Primary level of health care comprises exchange of basic, utilitarian and essential services between the individual/family and health care providers. The health care services are provided even to the ordinary individual of the society, i.e. at the 'grass-root' level. In India, this care is provided by primary health centers, and their sub-centers, supplemented by the services of the village health guides, the anganwadi workers and trained dais. These services are also called as 'Primary Health Care'.

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2. Secondary Level of Health Care

The health care services of the secondary level are made available for individuals having complex issues which cannot be dealt at primary level. They are provided by hospitals and specialized units. Therefore, remedial services are provided in Taluka Hospitals and Community Health Centers. These centers are also served as the First Referral Level/First Referral Units (FRU).

3. Tertiary Level of Health Care

The healthcare services at the tertiary level are specialized services available for individuals. The specialized services are provided by the apex or regional institutions such as government teaching institute for example, All India Institute of Medical Sciences, District hospitals, and specialized high-tech hospitals. These institutions not only provide high-tech diagnosis and highly specialized (superspecialty) care, but also have better planning and managerial skills. They also conduct training programs and research activities.

Private health sector is a growing industry in India, providing high amount of economic growth to the health industry. This industry includes both Secondary and Tertiary levels of healthcare. In order to provide good quality service to people, it is important to use resources in a judicious and efficient manner so that health improvement can take place. But in India, as of now more than half of the budget is spent in providing curative care rather than preventive or primary services, which leads to more investment but lower revenue generation.

The latest studies on health care for Schedule caste revealed that 38% of health services are utilized from private medical facilities whereas 28% are availed from the government health facilities. An additional study presented that the poor population of urban areas in Calcutta avails public health facilities only for emergency situations and prefer private facilities for regular care. Therefore, these studies imply that access to healthcare facilities do not depend only on infrastructure and supplies but also on the location, social and economic factors and the quality of the services.

The role of private healthcare providers is increasing nowadays in providing services to people who need assistance. The private healthcare structure is divided into two parts: profit and non-profit organizations. On the other side, public healthcare primarily constitutes community healthcare centers, primary health centers and sub-centers. And these centers are extended into sub-sections based on the provision of facilities, services and resources. Though, the secondary healthcare system is recognized as sub-district hospitals. These hospitals are established based on the health needs of the districts. Furthermore, the tertiary level of healthcare includes the district hospitals and teaching hospital which are associated with medical colleges.

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India has twenty nine states and seven union territories and further divided into districts and blocks. Since the population of India stands after China around 1.25 billion, it has been challenging to maintain the health care system and structures fulfilling the needs of our population post-independence. Therefore, the public and private healthcare systems needed comprehensive planning and management, and required strong policies to implement in India.

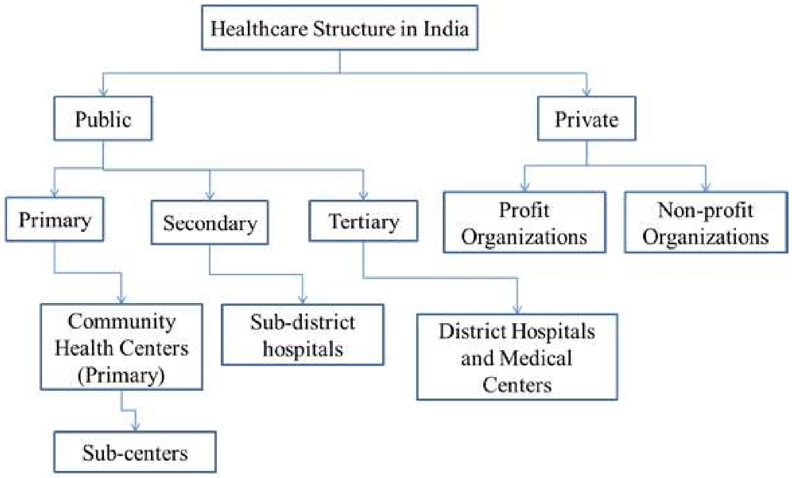


Fig. 13.2 *Healthcare Structure in India*

1. Sub Centers

A Sub Centre is planned in rural areas to provide healthcare services. They are fully secured and covered by the national government. At least two workers (one male and one female) are required in mandates to assist a population of about 5000 people. The population criterion is limited to 3000 inhabitants for dangerous, hilly or remote locations. These sub centers are working to encourage and persuade rural people towards healthy nutrition and habits of wellbeing in a long run.

2. Primary Health Centers

The primary health care centers are established in advanced rural areas, for the population of about 30,000 or more and it is limited to a population of about 20,000 for dangerous or hilly or remote locations. Their centers are expected to have clinics with doctors (1 Medical officer and 1 AYUSH), 4-5 beds and a pharmaceutical facility. The patients can be referred from sub-centers to the primary health center to get more advanced treatment. As compared to sub centers, the primary health centers are supported by the state government instead of the national government.

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3. Community Health Centers

The community health centers are also funded by the state government and have better and superior facilities than primary health centers. Here, the population covered is about 1,20,000 while it is limited to 80,000 for hilly and remote areas. There are around 30-50 beds to treat patients needing admission. These centers have a physician, anaesthetist, surgeon, ophthalmologist, gynaecologist and a paediatrician. The patients from these centers can be referred to the general or district hospitals, when required. This center acts as a referral unit for four primary health centers and also considered as first referral units for intensive care, blood storages, deliveries and new born childcare.

4. District Hospitals

The district hospitals are considered as a final referral center for the primary and secondary health care for public. Every district is expected to have at least one hospital in India, whereas in practice only 605 hospitals are available in 640 districts. The number of beds required is between 70 to 500 which is depending upon the population of the district and its needs.

5. Medical Colleges

There are medical colleges and research centers or hospitals that are controlled by the national government, like one of the largest and renowned centers is All India Institutes of Medical Sciences (AIIMS). These hospitals or centers are well equipped with special and advanced facilities. There are also regional special centers that may be controlled jointly by state and national government like regional cancer center.

6. Profit and Non-profit Organizations

These organizations are categorized into the private sector. The private hospitals are profit making units and may have the advanced and modern facilities based on the hospital dimensions. The patients are required to pay for the health care services themselves from out of their pocket. The private organizations are also responsible to manage the hospitals on their own. On the other hand, non-profit organizations have different sources of funding such as donations or under government schemes. The patients do not have to take responsibility of the expenses or may have to do a minor contribution towards health care expenses, while the organizations get managed by the funding sources.

Check Your Progress

11. Who provides specialized health services? Give examples.
12. What does public health care constitute?
13. Where are primary health centers established?

13.5 CURRENT TRENDS IN PRIVATE HEALTH CARE IN INDIA

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At the current juncture, amid the mayhem created by Covid-19, the one sector that has become the most important is the healthcare sector. The domain of healthcare extends from hospitals, medical devices, clinical trials, outsourcing, telemedicine, medical tourism, health insurance, and medical equipment. In the Indian context, the healthcare sector is growing at a brisk pace. Private players have come up remarkably well strengthening coverage and services.

The Indian healthcare sector is catered to by the public and the private sector. While the government sector comprises of limited secondary and tertiary care institutions in the form of primary healthcare centres (PHCs') in the rural areas, it is the private sector that provides the majority of services in the form of secondary, tertiary, and quaternary care institutions with a major concentration in metros and tier I and II cities. The vast pool of well-trained medical professionals at India's disposal is a major competitive advantage. Moreover, the cost-vis-a-vis quality in the accessibility of healthcare in India is among the best in Asia and Western nations.

Even though the public sector plays a key role in shaping the healthcare sector trends in India, the sheer magnitude of the workload causes regulatory failures. It is because of this reason that the private sector thrives. During recent times, in the unprecedented situations that prevail in most economies around the world, the private healthcare sector has thrived. In India, over a period of 18 months when most industries were restructuring operations or optimizing their costs, the Indian healthcare industry was piling numbers, both relating to employment and profits. Presently there are burgeoning opportunities in main healthcare and allied services. With rising opportunities, there is a rise in demand for trained personnel especially in the areas of nursing, Paramedics, Technicians, and Emergency medicine specialized doctors.

The private sector has been quick to grab the opportunities and has successfully brought up many specialist medical care hospitals either in the single-specialty or multi-specialty formats in several tier II and tier III cities. Other allied businesses have also been taken up by the private sector bringing about a boom in the healthcare arena. Nursing homes are growing at the rate of 20 %, while medical equipment is growing at 15%, clinical lab diagnostics at 30%, imaging diagnostics at 30 %, and other services that include aesthetics and weight loss, retail pharmacy, training, and education are expanding at the rate of 40%.

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The major trends that are finding favour in the field of healthcare are as follows:

1. **Health Insurance:** The Indian health insurance sector is showing a promising trend. As per the study carried out jointly by Mckinsey and CII, the estimated number of potential insurable lives is pegged at 315 million. This translates to Rs.34650 crores in terms of health insurance premiums.
2. **Telemedicine:** Telemedicine is the result of the combination of telecommunication and information technology to deliver health care at distant locations. In these times of COVID and its associated risks, telemedicine has received wide acceptance. This is actually a very potent tool to address two major challenges—lack of manpower and accessibility; both these factors affect India's health care sector to a very great extent. An initiative taken by the government, in collaboration with Apollo Hospitals, has been able to connect 60,000 common service centres across the country. This has benefitted citizens irrespective of their geographical location. Mobile phones, with their increasing penetration in India, are also playing a significant role in creating awareness of health.
3. **Medical Tourism:** India has become a choice destination for medical tourism. The private sector has helped in raising the popularity of this sector by providing state-of-the-art private hospitals and diagnostic conveniences, professionally groomed English speaking medical personnel at a comparatively lower cost than what is available in other developing countries. India's medical tourism sector is expected to rise exponentially, touching up to 30% per year. This in turn would translate to a wide spectrum of opportunities in employment and all other related medical fields.
4. **Diagnosis:** Progressively with the continuous advancements in technological and improved efficiency, the diagnostics sector has been witnessing phenomenal growth. The Diagnostic medical imaging has shown a registered high figure of achievement. Diagnostic imaging device sector in India is poised to take off in a really big way and is estimated to register a robust growth rate through 2022. During the past decade or so, India has gradually transitioned from analog to the digital mode and imaging solutions have now become less expensive. With CT, PET and MRI scans, or advanced ultrasound imaging, major manufacturers, and suppliers of these high-technology imaging systems are ready to provide products that cater to the needs of the Indian health care scenario.

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5. **Emergency care:** Every year there is a spurt in the development of smartphone apps that aim to help manage medical emergencies. Looking to bring about an overall transformation in emergency medical care services, various path-breaking initiatives like a network of traffic management, fast deployment of ambulance and emergency health care workers, etc., have helped in improving the way medical emergencies are handled. The creation of 'green corridors' to facilitate transportation of hearts for transplantation during peak hours in cities like Chennai, Mumbai, and Kochi was a fine example of emergency health care. Emergency medicine is a rapidly evolving specialty which has received increased recognition over the past few years.

Conclusion: For a long time people have viewed private providers of health care sectors to be money-minded and to be working on business models that encourage unnecessary diagnostic tests and surgical procedures. While this may be partially true at times, Indians are still opting for the private sector in overwhelming numbers. This is primarily because the alternative public healthcare system is not always the best and they are often short on matters of health, cleanliness, and sanitation- the basic tenets of any healthy healthcare system. Many medicines and tests are not available in the public sector, so patients have to go to private shops and laboratories. With no dearth of resources and a high level of commitment, the private sector in the healthcare sector is poised for high growth.

Check Your Progress

14. Which two challenges can telemedicine address?
15. How has the private sector helped in raising the popularity of medical tourism?

13.6 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. The Eighth Plan could not take off in 1990 due to the fast changing political situation at the Centre and the years 1990-91 and 1991-92 were treated as Annual Plans.
2. Some of the main economic outcomes during the Eighth Plan period were rapid economic growth (highest annual growth rate so far – 6.8 %), high growth of agriculture and allied sector, and manufacturing sector, growth in exports and imports, improvement in trade and current account deficit.

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3. The targets of the Eleventh Plan included reduction in gender gaps in literacy and wage rate, reduction in Infant & maternal mortality rates, improvement in literacy, access to potable drinking water, cleaning of major polluted rivers, etc.
4. There are several structural problems in the health care system like the lack of integration between disease control and other programmes in the social sector, sub-optimal use of traditional systems of medicines, weak regulatory systems for drugs as well as for medical practice, and poor capacity in public health management.
5. Responsiveness of health systems is assessed by WHO on users' perception of services on seven parameters, namely choice, communication, confidentiality, dignity, basic amenities, prompt attention and autonomy.
6. Two objectives of comprehensive primary health care are:
   (i) Under Ayushman Bharat, scale-up a new vision for comprehensive primary health care across the country, built on the platform of health and wellness centres (HWCs).
   (ii) Provide quality ambulatory services for an inclusive package of diagnostic, curative, rehabilitative and palliative care, close to the people.
7. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people'.
8. The goal of the National Health Policy 2017, is to attain the highest possible level of health and well- being for all age groups through a preventive and promotive healthcare orientation in all developmental policies. It also aims at universal access to good quality healthcare services without anyone having to face financial hardship as a consequence.
9. The National Health Policy proposes a potentially achievable target of raising public health expenditure to 2.5% of the GDP in a time bound manner.
10. The order of preference for strategic purchase would be public sector hospitals followed by not-for-profit private sector and then commercial private sector in underserved areas, based on availability of services of acceptable and defined quality criteria.
11. Specialized health services are provided by the apex or regional institutions such as government teaching institute for example, All India Institute of Medical Sciences, District hospitals, and specialized high-tech hospitals.
12. Public healthcare primarily constitutes community healthcare centers, primary health centers and sub-centers. And these centers are extended into sub-sections based on the provision of facilities, services and resources.

13. The primary health care centers are established in advanced rural areas, for the population of about 30,000 or more and it is limited to a population of about 20,000 for dangerous or hilly or remote locations.
14. Telemedicine is a very potent tool to address two major challenges—lack of manpower and accessibility; both these factors affect India's health care sector to a very great extent.
15. The private sector has helped in raising the popularity of medical tourism by providing state-of-the-art private hospitals and diagnostic conveniences, professionally groomed English speaking medical personnel at a comparatively lower cost than what is available in other developing countries.

13.7 SUMMARY

- The first Five-year Plan was launched in 1951 and two subsequent five-year plans were formulated till 1965, when there was a break because of the Indo-Pakistan Conflict.
- Simple aggregative Harrod Domar Growth Model was again used for overall projections in the second plan and the strategy of resource allocation to broad sectors as agriculture & Industry was based on two & four sector Model prepared by Prof. P C Mahalanobis.
- Failure of Third Plan that of the devaluation of rupee (to boost exports) along with inflationary recession led to postponement of Fourth FYP. Three Annual Plans were introduced instead. Prevailing crisis in agriculture and serious food shortage necessitated the emphasis on agriculture during the Annual Plans.
- Recognizing that economic growth can't be the only objective of national plan, Tenth Plan had set 'monitorable targets' for few key indicators (11) of development besides 8 % growth target.
- The Eleventh Plan set a target of 34.8 per cent for domestic savings and 36.7 per cent for investment after experiencing a rising level of domestic savings as well as investment and especially after emergence of structural break during the Tenth Plan period.
- The Twelfth Plan therefore emphasizes that our first priority must be to bring the economy back to rapid growth while ensuring that the growth is both inclusive and sustainable. The broad vision and aspirations which the Twelfth Plan seeks to fulfil were reflected in the subtitle: 'Faster, Sustainable, and More Inclusive Growth'.
- The Directive Principles of State Policy in the Constitution of India mandate 'improvement of public health' as one of the primary duties of the State.

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- A health system is the sum total of all the organizations, institutions and resources whose primary purpose is to improve health. The 11th Plan had set six health outcome indicators as time-bound 'goals'.
- Progress towards the goals would eventually depend on how the three vital functions, namely, provision of health care services, its financing, and stewardship of inter-sectoral policies that may have a bearing on health are actually carried out.
- The Niti Aayog has come up with a document 'Strategy for New India @ 75' which has identified 41 different areas that require either a sharper focus on implementing the flagship schemes already in place or a new design and initiative to achieve India's true potential.
- The Niti ayog aims to achieve a doctor-population ratio of at least 1:1400 (WHO norm 1:1000) and nurse population ratio of at least 1:500 (WHO norm 1:400) by 2022-23.
- As per the World Health Organization (WHO), a health policy refers to decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society. Health policies are of various types such as global health policy, public health policy, national health policy of a country, healthcare services policy, mental health policy, and so on.
- Disease prevention and health promotion require addressing a much broader set of factors and health policies that shape health-related behaviours of a population at large.
- The primary objective of the National Health Policy, 2017, is to educate, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions
- The indicative, quantitative goals and objectives are outlined under three broad components viz. (I) health status and programme impact, (II) health systems performance and (III) health system strengthening.
- The National Health Policy, 2017 recognizes and builds upon preventive and promotive care as an under-recognized reality that has a two-way continuity with curative care, provided by health agencies at same or at higher levels.
- The policy recognizes the special health needs of tribal and socially vulnerable population groups and recommends situation specific measures in provisioning and delivery of services. The policy advocates enhanced outreach of public healthcare through Mobile Medical Units (MMUs), etc.
- The policy aspires to provide at the district level most of the secondary care which is currently provided at a medical college hospital. Basic secondary care services, such as caesarean section and neonatal care would be made available at the least at sub-divisional level in a cluster of few blocks.

- The policy duly acknowledges the roadmap of the 12th Five Year Plan for managing human resources for health. The policy initiatives aim for measurable improvements in quality of care. Districts and blocks which have wider gaps for development of infrastructure and deployment of additional human resources would receive focus.
- An important focus area of the urban health policy will be achieving convergence among the wider determinants of health – air pollution, better solid waste management, water quality, occupational safety, road safety, housing, vector control, and reduction of violence and urban stress.
- Primary level of health care comprises exchange of basic, utilitarian and essential services between the individual/family and health care providers.
- A Sub Centre is planned in rural areas to provide healthcare services. They are fully secured and covered by the national government. At least two workers (one male and one female) are required in mandates to assist a population of about 5000 people.
- While the government sector comprises of limited secondary and tertiary care institutions in the form of primary healthcare centres (PHCs') in the rural areas, it is the private sector that provides the majority of services in the form of secondary, tertiary, and quaternary care institutions with a major concentration in metros and tier I and II cities.
- Diagnostic imaging device sector in India is poised to take off in a really big way and is estimated to register a robust growth rate through 2022. During the past decade or so, India has gradually transitioned from analog to the digital mode and imaging solutions have now become less expensive.

13.8 KEY WORDS

- **Harrod–Domar model**: It is a Keynesian model of economic growth. It is used in development economics to explain an economy's growth rate in terms of the level of saving and of capital.
- **Head Count Ratio:** It is the population proportion that exists, or lives, below the poverty threshold.
- **Gross Domestic Product (GDP):** It is the standard measure of the value added created through the production of goods and services in a country during a certain period. As such, it also measures the income earned from that production, or the total amount spent on final goods and services (less imports).

- **Child Sex Ratio:** It is defined as the number of females per 1000 males in the age group 0–6 years.
- **Decentralization:** It is the process by which the activities of an organization, particularly those regarding planning and decision making, are distributed or delegated away from a central, authoritative location or group.
- **Zoonosis**: It is an infectious disease caused by a pathogen (an infectious agent, such as a bacterium, virus, parasite that has jumped from a non-human anima to a human.
- **Primary Health Centres (PHCs):** These are state-owned rural health care facilities in India. They are essentially single-physician clinics usually with facilities for minor surgeries.

13.9 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. Why was the First Plan successful?
2. Write a short note on the Fourth Plan.
3. What did the broad vision for the Eleventh Plan include?
4. List the monitorable targets of the plan for health.
5. Write a short note on the Structure of the Steering Committee Report.
6. List the four major changes in the current health policy.
7. What is the primary objective of the National Health Policy, 2017?
8. Write a short note on community health centers.

Long-Answer Questions

1. Analyze the objectives of the Fourth and Fifth Plans.
2. Discuss the objectives and outcomes of the Twelfth Plan.
3. Explain Niti Aayog's schemes pertaining to health policy.
4. Elaborate upon the key principles of the National Health Policy.
5. Analyze any two objectives of National Health Policy.
6. Explain the tertiary level of health care.

13.10 FURTHER READINGS

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UNIT 14 CONTEMPORARY ISSUES IN HEALTH SERVICES MANAGEMENT

NOTES

Structure

14.0 INTRODUCTION

There lie a lot of changes in the contemporary health care system which comes from various different sources. From the beginning of the 20th century, infectious diseases were present through various wars and causalities which took place one finds that now we have reached to the level of chronic illness in elder generation. In current times, we find that people are now dying at a more advanced level and more and more deaths are taking place due to various diseases and illness such as cancer, cardiac problem, neurological problems, and so on.

Different opinions have been created by various economists. Many hold he view that whether such spending happen to be representing a state of risk to the overall economic well-being of the states. Many concerns are developed by people such as below mentioned ones:

1) When a society spends more on the sector of health and health care then it is perceived that the particular society happens to spend less on other goods and services products. Such process is known as displacement.
2) The market of the health care is seen as imperfect.
3) The economy of the health care is quite large, in the sense that not just monetary wise but in terms of number of people being employed in it thereby when any sort of changes happen in the same it implies that substantial and painful economic effects.

Furthermore, a study conducted in 2003 shows that patients treated in higher spending regions and areas of the United States are neither found to have better

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health outcomes or greater level of satisfaction with their care than those patients who are treated in lower spending regions of the world. Such type of practice existed due to various reasons such as higher frequency level to visit a physician, taking up of more tests, more extensive use of hospital care and health care services, and so on. As rightly said by the chairman of the Juran institute named A. Godfrey who said that "at least 20 percent of the lab tests are unnecessary. Every infection is a waste. Every complication after open heart surgery is waste and triples the bill".

Furthermore, a lot of studies conducted show that the aging up of the population is one of the key factor that drives the increase in health care expenses. But other studies shows something else. For instance study conducted in 1992 showed that total NHE in 2030 would be approximately $16 trillion which shows an average growth rate of 8.3%. Out of this it is only a small portion of 0.5% of this 16trillion $ which would be attributed to the aging of the population. Similar observations were found in the Canadian population studies.

14.1 OBJECTIVES

After going through this unit, you will be able to:

- Discuss the contemporary issues in health services management
- Analyze the state of medical technology and the steps involved in risk management
- Describe intersectoral collaboration and learning management in the health sector

14.2 QUALITY MEASURES IN HEALTH CARE

One of the most important sociological concerns which always remains in the mind is the interaction which exists between the individual and the larger society of which the individual is a part. Many sociologists and thinkers have mentioned and talked about this in detail in their various works. For instance, it is found in the works of Giddens' structuration theory, or in the works of Garfunkel's ethnomethodology, or in the works on institutional theory given by Scott.

Furthermore, one finds that there is presence of a wide range of infrastructural technologies which are used in healthcare services that support work activity and many quality improvement initiatives and safety interventions hinge on the introduction of artefacts or tools to bring about behavioural change in the workplace. A major contribution of the study of Strauss et al on the social organization of medical work was the acknowledgement of patients and families and contribution to healthcare concerns that were subsequently taken up in their research on chronic disease management and on the work on burden of treatment.

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The performance in any field of medical organization can be classified into the following three categories: measures of health care, measures of process, and measures of patient outcomes. If we talk about the structural measures, we find that they are the most traditional measures that can be taken up in outcome prediction. They are found to be static and artificial. Most of the times we find that the structural measures are seen as better predictors of hospital performance than any other process. Furthermore, they are found to be quite effective as compared to others. For example, higher hospital and surgeon procedure volume is linked up with not just lower operative mortality but also with lower perioperative morbidity.

Health Care Workforce

According to WHO, health care workforce holds for the greatest proportion of spending. In earlier times, the growth of existing professions was seen. Such changes are found to be the result of many types of developments which took place in technology, education, and so on. These changes have a number of implications for traditional workforce boundaries. The various types of unskilled workers such as healthcare assistants and support workers take up various kinds of roles which, in earlier times, were just performed by health care professionals.

Now a days, we find that there has been an increase in the number of health care providers and service providers who work within an inter professional team. One good example of such nature of professional boundaries are orthopaedic surgeons in the United States. The vice president of the American Academy of Orthopaedic Surgeons stated the following: “a decade or two ago, when we were fat and sassy, we decided to limit our practices to those aspects that were fun and well remunerated. We chose not to counsel little old ladies about the prevention and treatment of osteoporosis; we chose not to provide foot care services in our offices” (Heckman 1998: 6).

Furthermore, the various concepts of Proletarianization, deprofessionalization, and post- professionalism are present which explain the challenges to traditional professional power. Proletarianization happens to predict upon the decline of medical power which is seen as the product of deskilling of medical health care service providers and professionals. Deprofessionalization describes ‘a loss of professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos and expectations of work autonomy and authority over clients’. Post-professionalism means the loss of having access to knowledge which is generally found to arise due to the growth in the technological advancement and having access to information. Deprofessionalization describes ‘a loss of professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos and expectations of work autonomy and authority over clients’.

Furthermore, Wills (1989) has described and highlighted four different approaches which are used by the health sector in order to maintain its professional

dominance over various other disciplines or theories. The various approaches are as follows:

1) The subordination of other workers
2) Restricting the occupational boundaries of other workers;
3) Exclusion, by limiting access to registration and therefore, legitimacy; and
4) Incorporation of the work of other disciplines into medical practice

Medical Technology

According to authors Theodore H. Tulchinsky and Elena A. Varavikova, in their book, *The New Public Health*, medical technology can be defined as the application of science to develop solutions to health problems or issues such as the prevention or delay of onset of diseases or the promotion and monitoring of good health. It includes medical and surgical procedures, drugs, equipment and facilities, and the organizational and supportive systems within which care is provided. Some of the new medical technologies of recent times include the following:

- Virtual reality
- Precision medicine
- Artificial organs
- 3-D printing
- Wireless brain sensors
- Robotic surgery

Learning Management

Healthcare is an area that is reinvented over and over, taking technological advances as a pillar of development and they need to adapt to new technologies, trends and methods to medical, administrative and educational practices to be at the forefront and deliver an increasingly, more complete and advanced service. The best IT solution for training is the acquisition of a Learning Management System for healthcare.

The reason why a learning management system is needed is as follows:

- It streamlines to thousands of hospital staff and medical professionals
- It facilitates the learners to study anywhere anytime
- It accommodates and manages practically innumerable different healthcare courses
- It responds quickly to new training trends & demands
- It provides tools to help assess its own effectiveness

Major Health Issues

India is seen as one of the pioneers of health service planning and health care system. It was in 1946 that the Health Survey and Development Committee, which was headed by Sir Joseph Bhore recommended to establish a comprehensive health service. Furthermore, under the Constitution also one finds that health is found to be a very serious issue under the state subject However, a number of problems are found to exist under the category of health such as those of water supply, sanitation, access to toilet facilities, and so on. Let us look at the few major health problems in India which are evident at a large level:

1. **Malnutrition:** According to a 2005 report, 42% of India's children who are below the age of three, are found to be malnourished. Further, the rate of economic growth of India increased, malnutrition of child just dropped by the rate of 1 percent only. Apart from this, there exist various nutritional deficiencies in the people such as Protein Energy Malnutrition (PEM), Iodine Deficiency Disorder (IDD), Vitamin A deficiency and anaemia.
2. **High infant mortality rate:** Approximately 1.72 million children die before reaching the age of one year. A study which was conducted by the Future Health Systems Consortium in Murshidabad, West Bengal showed that there are various barriers which exist in context of immunization. These are geographic location, unqualified health workers, lack of infrastructure, etc.
3. **Disease:** There exist various Diseases such as dengue fever, hepatitis, tuberculosis, malaria and pneumonia which affect a large number of people. Further, one finds that India is ranked 3rd among countries with the largest number of HIV infected patients.
4. **Poor sanitation:** More than 122 million households have no access to basic facilities such as toilets, 33% lack access to latrines, and over 50% of the population is found to defecate in the open. Such things lead to unhealthy conditions and make people much more vulnerable to falling sick or getting infected. All of this further leads to the spread of many more kinds of disease through bacteria, virus, fungus and so on.
5. **Safe drinking water:** Only 26% of the slum population has access to safe drinking water and 25% of the total population has drinking water on their premises.
6. **Kala-Azar:** It is also one of the most serious health problems that exists in the country.

Apart from these, female related health issues also exist at a large scale. Let us look at few of them in brief. Most women are found to be malnourished and especially if we compare them with men, they are even more so. In rural areas we find the condition even more worsened. As such, one finds that girls and women face nutritional discrimination within the family, and are anaemic and malnourished.

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This is the case mostly because women are given less food as compared to men. The situation is so that even pregnant women and the ones who are lactating are also provided with less food, which results in malnourishment. It is one of the most severe and increasing problems among women in India that leads to higher mortality rates.

14.3 INTERSECTORAL COLLABORATION

The term intersectoral collaboration in basic terms means collective action that involves more than one specialized agency that happens to perform different roles for a common purpose. Recently, the WHO promoted the concept of Intersectoral Action for Health (IAH) as "a recognized relationship between part or parts of the health sector with parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone".

Furthermore, according to WHO, health is defined as the following: a state of complete physical, mental and social well-being. If we talk about primary health care, we find that its earlier strategies required a very wide range of inputs generally which are procured from a range of sectors. For instance, the literacy improvement is seen to be task of the sector of education, but developing technology is multi sectorial but might include various inputs from technology and industrial sectors as well.

If we talk about the Millennium Development Goals, we find that they happen to include a range of things such as reduction of child death, improvement in maternal health, and combating HIV/AIDS, malaria and other major diseases. All of these are highly dependent on various kinds of other sectors as well. For instance, optimal public power supply is required for the proper functioning of and maintenance of vaccine cold chains in order to maintain and stabilize potencies of vaccines to reduce child death as well to provide with blood banks. Further, the Millennium Development Goals are found to be associated with eradication of extreme poverty and hunger along with providing suitable and good environment conditions in which an individual is able to survive.

Now, one finds that there are many problems which are seen to be interlinked with the Intersectoral collaboration as well. Generally, we find that the problem which lies is seen to be associated with the scantiness of systematic programmatic experiences. For instance, we find that the major Intersectoral approach in Nigeria's national response to the control of HIV/AIDS lies in the fact that it includes National Action Committee on HIV/AIDS (NACA) with membership drawn from the justice, social welfare, health, education, information, and various other sectors.

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Intersectoral governance reforms

National System for Food and Nutritional Security (SISAN) was found to be formalized in the Federal Law on Food and Nutrition Security (2006). It included various things which are mentioned as follows:

1. The National Conference on Food and Nutritional Security
2. The National Council of Food and Nutritional Security
3. Various agencies and entities which implement different policies for food and nutritional security at federal, state and municipal levels
4. Private institutions that respected the goals of System for Food and Nutritional Security

Similarly, if we talk about the Food and nutritional security we find that it was focusing on many things as well. As such, the various policies on food and nutritional security must seek to:

- Expand the access to food
- ensure biodiversity
- promote good health and nutrition
- ensure the safety and quality of food
- improve access to information
- implement participatory public policies

14.4 RISK MANAGEMENT

Let us begin by highlighting in brief as to where risk management can be beneficial:

(a) Enterprise Risk Management (ERM): Comprehensive risk management of the organization from top down including financial and business viability.
(b) Patient care (Clinical)
(c) Medical staff
(d) Non-medical staff
(e) Finance, budgeting, cost-benefit etc.
(f) Managerial
(g) Project risk management such as scope, time, cost, human resources, and so on
(h) Facility management and safety

Now, if we talk about the basic definition of risk management for healthcare we find that it means, in simple terms, that it is a collective effort to assess and identify risk to patients, visitors, or staffs for that matter. Furthermore, we find that

Risk management, as a process, is found to use a five step management decision-making model which is as follows:

1. Step 1: Establish the context
2. Step 2: Identify risks
3. Step 3: Analyze risks
4. Step 4: Evaluate risks
5. Step 5: Treat/Manage Risk

Establish the context: In risk management, the context is seen to occupy and hold a very great importance. As such we find that ICU (Intensive care unit), O.R (Operation room), E.R (Emergency room), blood transfusion services, CCU (coronary care unit) all of these hold utmost importance in relation to the care of the patients.

Identify the Risks: The healthcare professional and the healthcare service provider often, at times, is found to be aware of the risks which are involved. Let us discuss few of its sources:

(a) Discussions with department chiefs, managers and staff
(b) Patient Tracer Activity
(c) Retrospective screening of patient records
(d) Reports of accreditation bodies
(e) Incident reporting system & sentinel events
(f) Healthcare associated infections (HAI) reports
(g) Executive committee reports
(h) Facility management & safety committee report
(i) Patient complaints and satisfaction survey results
(j) Specialized committee reports

Similarly, analyzing the risk involved is also very crucial aspect. As such when one happens to see the existing control measures, it is important that one takes into consideration their adequacy, implementation and effectiveness. There exist various measures which should be taken into consideration in order to reduce the risk involved. These range from policies, procedures, protocols, guidelines, alarms, insurance coverage programs, training, Emergency arrangements, and so on.

Similarly, after one happens to analyze the risk involved, it is quite important that the treatment for the risk which has occurred is also taken care of. Risk treatment plan should have:

- Proposed actions
- Resource requirements
- Person/s responsible for action
- Timeframes (Dates for actions to be completed and date for review.)

Controlling the Risk: The most effective methods of risk controls are those that rebuild systems and processes so that the chances of a negative outcome are reduced. Other risk management measures include reducing the likelihood of risk and / or reduction in the magnitude of the risk impact.

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Transferring the risk: Transferring the risk such as that of party bearing or sharing some part of the risk through contractual terms or any kind of insurance

Avoiding the risk: This is achieved indiscriminately continuing work containing unacceptable risks, choosing another acceptable job.

Monitor & Review: Monitoring and Reviewing utilizes the following sources of information:

(a) Incident reporting
(b) Clinical Audit indicators
(c) Patient Tracers
(d) Safety rounds
(e) Patient complains
(f) Satisfaction survey
(g) Staff complains
(h) Medical records

Residual Risk: Residual risk is the risk left behind use controls. It is not always possible to eliminate all dangers. Instead, we are taking steps to reduce the risk to an acceptable level. The risk that remains is the remaining risk.

Check Your Progress

1. In which works is a discussion of the concept of interaction found?
2. What does deprofessionalization describe?
3. Name some common nutritional deficiencies.
4. What should the policies on food and nutritional security seek to do?

14.5 ANSWERS TO CHECK YOUR PROGRESS QUESTIONS

1. A discussion of 'interaction' is found in the works of Giddens' structuration theory, or in the works of Garfunkel's ethnomethodology, or in the works on institutional theory given by Scott.
2. Deprofessionalization describes 'a loss of professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos and expectations of work autonomy and authority over clients'.

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3. Some common nutritional deficiencies are Protein Energy Malnutrition (PEM), Iodine Deficiency Disorder (IDD), Vitamin A deficiency and anaemia.
4. The various policies on food and nutritional security must seek to:
   - Expand the access to food
   - ensure biodiversity
   - promote good health and nutrition
   - ensure the safety and quality of food
   - improve access to information
   - implement participatory public policies

14.6 SUMMARY

- A major contribution of the study of Strauss et al on the social organization of medical work was the acknowledgement of patients and families and contribution to healthcare concerns that were subsequently taken up in their research on chronic disease management and on the work on burden of treatment.
- According to WHO, health care workforce holds for the greatest proportion of spending. In earlier times, the growth of existing professions was seen. Such changes are found to be the result of many types of developments which took place in technology, education, and so on.
- Proletarianization happens to predict upon the decline of medical power which is seen as the product of deskilling of medical health care service providers and professionals.
- Post-professionalism means the loss of having access to knowledge which is generally found to arise due to the growth in the technological advancement and having access to information.
- According to a 2005 report, 42% of India's children who are below the age of three, are found to be malnourished. Further, the rate of economic growth of India increased, malnutrition of child just dropped by the rate of 1 percent only.
- The term Intersectoral collaboration in basic terms means collective action that involves more than one specialized agency that happens to perform different roles for a common purpose.
- If we talk about the Millennium Development Goals, we find that they happen to include a range of things such as reduction of child death, improvement in maternal health, and combating HIV/AIDS, malaria and other major diseases.

- In risk management, the context is seen to occupy and hold a very great importance. As such we find that ICU (Intensive care unit), O.R (Operation room), E.R (Emergency room), blood transfusion services, CCU (coronary care unit) all of these hold utmost importance in relation to the care of the patients.
- The most effective methods of risk Controls are those that rebuild systems and processes so that the chances of a negative outcome are reduced.

14.7 KEY WORDS

- **Operative Mortality:** It is defined as any death, regardless of cause, occurring (1) within 30 days after surgery in or out of the hospital, and (2) after 30 days during the same hospitalization subsequent to the operation.
- **Deprofessionalization:** It refers to the decreasing distance, in knowledge or education, between doctors and patients or the rise of consumerism generally.
- **Enterprise Risk Management (ERM):** It includes the methods and processes used by organizations to manage risks and seize opportunities related to the achievement of their objectives.

14.8 SELF ASSESSMENT QUESTIONS AND EXERCISES

Short-Answer Questions

1. How can performance in any field of medical organization be classified?
2. Write a short note on structural measures.
3. List the approaches which are used by the health sector in order to maintain its professional dominance over other disciplines.
4. What is the present state of sanitation in India?

Long-Answer Questions

1. Discuss some major health problems in India which are evident at a large level.
2. Elaborate upon the concept of intersectoral collaboration.
3. Explain the steps involved in risk management.

14.9 FURTHER READINGS

NOTES

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